DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2025-26 JOINT BUDGET COMMITTEE HEARING AGENDA

Monday, January 6, 2025

9:00 am – 5:00 pm

9:30-10:20 PRESENTATION FROM RAC AUDIT VENDOR BERRY DUNN

10:20-10:30 BREAK

10:30-10:45 COMMISSION ON FAMILY MEDICINE

Presenters:

- **Dayton Romero: COFM Member**
  Congressional District 5 Representative
- **Elin Kondrad, MD: CAFMR Chair**
  Program Director, Colorado Association of Family Medicine Residencies (CAFMR) Board Member
- **Mattie Brand, DO, Resident Physician**
  Family Medicine Resident, HCA HealthOne Family Medicine Residency Program, Medical Center of Aurora
- **Lynne Jones**
  Executive Director, Colorado Commission on Family Medicine, CO Association of Family Medicine Residencies (COFM/CAFMR)

10:45-11:05 INTRODUCTION & HEARING OVERVIEW

Presenter:

- Kim Bimestefer, Executive Director

Topics:

- Medicaid Growth, Trends and Sustainability, Pages 1-12, Questions 1-3 in the packet, Slides 2-19

11:15-12:00 OFFICE OF COMMUNITY LIVING

Presenter:

- Bonnie Silva, Office of Community Living Director

Topics:

- Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) Overview, Pages 12-15, Questions 4-8 in the packet, Slides 21-29
- LTSS Cost Growth, Page 15-21, Questions 9-14 in the packet, Slides 30-36

- Keeping People in Community as Sustainable Growth Strategy, Pages 22-25, Questions 15-17 in the packet, Slides 37-40
- Investing in Workforce to Keep People in Community, Pages 25-27, Questions 18-20 in the packet, Slide 41-43

12:00-1:30 LUNCH

1:30-2:15 BEHAVIORAL HEALTH

Main Presenters:
- Cristen Bates, Behavioral Health Initiatives & Coverage Office Director
- Dr. Robert Werthwein, Senior Advisor for Behavioral Health and Access

Topics:
- Behavioral Health, Pages 27-30, Questions 21-23 in the packet, Slides 45-52
- Behavioral Health Initiatives and Coverage Office & Collaboration with the Behavioral Health Administration, Page 30-37, Questions 24-25 in the packet, Slides 53-55
- Prospective Payment System, Pages 37-39, Questions 26-28 in the packet, Slides 56-58
- Youth Systems of Care, Pages 39-46, Questions 29-34 in the packet, Slides 59-68
- Integrated Behavioral Health Services, Pages 46-49, Questions 35-38 in the packet, Slides 69-73

2:15-2:45 BUDGET REDUCTION DISCUSSION

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Reduction Options, Pages 50-73, Questions 39-46 in the packet, Slides 74-78

2:45-3:15 ELIGIBILITY, COUNTY ADMINISTRATION & CBMS

Main Presenters:
- Kim Bimestefer, Executive Director
- Rachel Reiter, Policy Communications and Administration Office Director
- Ralph Choate, Medicaid Operations Office Director

Topics:
- Eligibility, R7 County Administration, Pages 73-100, Questions 47-57 in the packet, Slides 79-85
- Colorado Benefits Management System, Pages 100-104, Questions 58-61 in the packet, Slide 86

3:15-3:25 BREAK

3:25-3:45 PROVIDER FEES

Main Presenters:

- Bettina Schneider, Chief Financial Officer

Topics:
- Provider Fees, Pages 105-120, Questions 62-70 in the packet, Slides 87-93

3:45-3:55 SAFETY NET & DENVER HEALTH

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Rural Safety Net Providers and Denver Health, Pages 121-125, Questions 71-72 in the packet, Slides 94-96

3:55-4:30 HB22-1298 COVER ALL COLORADANS

Main Presenters:
- Adela Flores-Brennan, Medicaid Director

Topics:
- Cover all Coloradans, Pages 125-135, Questions 73-80 in the packet, Slides 97-102

4:30-4:40 ALL PAYER CLAIMS DATABASE

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Colorado All Payer Claims Database, Pages 135-138, Questions 81-82 in the packet, Slide 103

4:40-4:50 R-8 MEDICAID ENTERPRISE SYSTEM

Main Presenters:
- Parrish Steinbrecher, Health Information Office Director

Topics:
- Colorado Medicaid Enterprise System, Pages 138-140, Questions 83-84 in the packet, Slides 104-108

4:50-5:00 COMMON QUESTION 01

Main Presenters:
- Bettina Schneider, Chief Financial Officer

Topics:
- Common Question 01, Pages 140-142 Questions C-01 in the packet, Slide 109

COMMON QUESTIONS, FOR WRITTEN RESPONSES ONLY

- Pages 142-164

Colorado Commission on Family Medicine
Report to the Joint Budget Committee, January 2025
Training Family Physicians for the State's Health Care Needs since 1977

Presenters:

- ***Dayton Romero: COFM Member***
  Congressional District 5 Representative
- ***Elin Kondrad, MD: CAFMR Chair***
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***Our vision*:** to promote high quality health care for all Coloradans by enhancing access to primary care, including rural and underserved communities, through the training of exceptional family physicians.

Our mission: to convene key leaders and stakeholders who support family medicine training to:

- Cultivate and develop a highly qualified family physician workforce in Colorado to appropriately meet the needs of the population, including rural and underserved communities, through recruitment, education, advocacy, and resource sharing.
- Evaluate and inform community, state, and national policy impacting delivery of advanced primary care and positive health outcomes for Coloradans.
- Be a powerful voice to elevate health care delivery for all Coloradans.

COFM FUNDING REQUEST:

THE COMMISSION ON FAMILY MEDICINE IS PROPOSING A 5%

DECREASE IN FUNDING FOR FY25-26

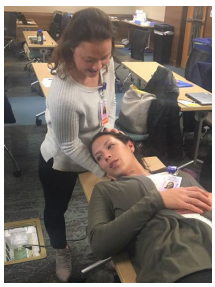
This would be a reduction of $118,627 GF and $ 118,627 FF and this would amount to a 5% decrease in the total appropriation.

Please see the detailed explanation of this reduction below.

Key Contributions to Colorado of the Commission on Family Medicine

- Family Medicine Resident Physicians (FMRP) touch over 2/3rds of Colorado counties during their training.
- FMRP providing direct patient care to over 100,000 individual patients annually, 67+% of whom are uninsured (7%) or Medicaid (45%) /Medicare (17%) beneficiaries.
- Physicians who train in Colorado tend to remain in the state (61% in2024).
- COFM is a unique collaborative vs. competitive model of recruiting new physicians to the state.






Access to primary care across Colorado

- Since its inception, COFM's mission to assure access to primary care in rural and other

underserved communities has driven its actions and efforts.

- FMRP clinics serve as safety net like clinics, caring for our most vulnerable and hard to reach.
- Four rural training tracks and over a dozen rural rotations feed FMRPs to communities and counties with the least access to primary care. Recent graduates now practice in Alamosa, Brush, Fruita, Granby, LaJunta, Meeker, Pagosa Springs, Wray, Yuma, and others.
- All residency programs have relationships with the federal qualified and community health centers in their communities and have also supplied those systems with physicians (Clinica, Pueblo Community Health, Peak Vista, Salud, STRIDE, Sunrise, Valleywide, and others).

Addressing health disparities and inequities

-67,000+ of the over 100,000 individual patients treated are uninsured, or Medicaid/Medicare beneficiaries.

-7 of the 10 programs host or partner to provide MAT/Opioid clinics and treatment.

-All 10 programs participate in a myriad of community service projects and programs.

-Engagement with schools/other educational institutions to share career experiences with students aspiring to heath careers.

Colorado continues to increase the average number of physicians practicing in rural communities with

2012 – 2023

FM Resident Graduates who stayed Colorado to Practice

Resident Graduate Years	Number of Residency Programs	Total Number of Graduating Residents	Resident Graduates Staying in Colorado	% of Resident Graduates staying in CO	Resident Grads Practicing in Rural Colorado	% of Resident Grads Practicing in Rural Colorado	Resident Grads practicing in Urban Underserved Colorado	% of Resident Grads practicing in Urban Underserved Colorado	Resident Grads joining Colorado FMR Faculty	% of Resident Grads joining Colorado FMR Faculty	Colorado Fellowship	% of Resident Graduates staying in CO Fellowships
2023	10	83	51	61%	8	16%	11	22%	10	20%	7	14%
2022	10	83	38	46%	8	21%	8	21%	5	13%	11	29%
2021	10	81	48	59%	9	19%	13	27%	4	8%	5	10%
2020	10	88	55	63%	8	15%	12	22%	5	9%	9	16%
2019	10	86	49	57%	12	24%	10	20%	9	18%	11	22%
2018	9	65	46	71%	6	13%	10	22%	7	15%	6	13%
2017	9	68	49	72%	11	22%	11	22%	7	14%	6	12%
2016	9	66	33	50%	7	21%	9	27%	4	12%	5	15%
2015	9	68	38	56%	7	18%	11	29%	2	5%	6	16%
2014	9	62	35	56%	7	20%	11	29%	6	17%	6	17%
2013	9	66	38	58%	6	15%	10	26%	1	3%	7	18%
2012	9	65	36	55%	3	8%	8	22%	2	6%	2	5%

time. From 2012 -2014, prior to the establishment of the rural training tracks, an average of about 10% of residents remaining in Colorado chose to practice in rural areas where in the past 3 years it is approximately 16%. Underserved community choice was 22% in 2023.

REDUCTION IN FAMILY MEDICINE RESIDENCY PROGRAMS

The Fort Morgan Family Medicine Residency Program will close its doors June 30, 2025, due to financial challenges with the program and the fact that the FQHC serving as the clinic for residency training will cease training residents. Any time that funding and community support for these programs fluctuates or is suspended, the impact on the availability of family physicians is felt across the entire health system in the state.

FUNDING REQUEST for FY2025-26 and ongoing:

COFM appreciates the pressures of the current budget situation as it is prepared to accept a 5% reduction in funding. This cut will reduce the level of funding to the rural training track program but still allow partial support for the new Denver Community Health Services-Montbello Clinic residency program, as described below.

Recommendations for Rural Training Track $2,500,000 total funds ($1,250,000 GF and $1,250,000 FF (note: original funds were $3,000,000 with $1,500,000GF & $1,500,000 FF) portion of line 140 in FY2025-26 and ongoing:

- $2,000,000 ($1,000,000 GF & $1,000,000 FF): continue to support the Alamosa and Sterling rural training tracks.
- $500,000 ($250,000GF & $250,000FF) The Rural Training Track program in Alamosa, supported by the Southern Colorado Family Medicine Residency Program in Pueblo, will take on one additional resident, filling one of the vacated positions by the Fort Morgan program closing.
- $262,746 ($131,373 GF and $131,373 FF) will be transferred to base funding to provide partial funds for the new Denver Community Health Services Montbello Clinic Residency Program. The remaining base funding support dollars will come from an equitable reduction across the other nine programs.

This proposal reallocates state funds to address increased access to care through training family physicians and:

1. Expands the Alamosa Rural Training Track program to sustain rural training of family medicine physicians in Colorado.
2. Assists to stand up the newly accredited Denver Community Health - Montbello Clinic which will train 12 residents annually, when it is fully instituted, in an FQHC setting and see over 10,000 patients and over 30,000 patient visits annually.
3. Provides additional residency training opportunities for the newly funded University of Northern Colorado medical school students. To be accredited, the medical school is required to assist in assuring residency slots for a minimum of 30% of their enrolled students (45 resident slots per UNC).
4. In an incredibly challenging budget year, uses **existing** funds to support a newly established program (Denver Community Health-Montbello) so that the state allocation is equitable across all ten family medicine residency programs
5. In a year when Medicaid members are experiencing challenges in access to care, supporting the state's family medicine residency programs which have on average 45% Medicaid members on their patient panels.

This adjusted distribution of funds will increase the Commission base funding by at $3,602,916 ($1,801,458 GF & $1,801,458 FF), reduce rural funding to $2,500,000 total funds ($1,250,000 GF and $1,250,000 FF) and the added family medicine residency positions remain at $2,700,000, $1,350,000GF & $1,350,000FF).

Negative impact of funding fluctuations in family medicine physician training

- Training family medicine resident physicians impacts the state's ability to deliver appropriate access to care; every time funding is decreased, that ability is diminished
- Since 2018, impart due to funding fluctuations and challenges, three programs have been closed: Rose Medical Center, Peak Vista Community Health Center, and in June 2025, the Fort Morgan rural training track
- These closures have resulted in sixteen fewer family physicians entering the workforce annually; 2/3 of whom remain in Colorado to practice, and half of those choose to practice in rural and/or underserved communities in the state. Colorado graduates on average 83 family medicine physicians annually.
- A recent article (see attached) in the Denver Post highlights that the physician shortage is not only felt in rural communities, but in every one of the state's 21 health districts (CDPHE data)
- The average family physician has about 2,000 patients on their care panels resulting in over 5,000 patient visits annually.
- Eliminating resident physician training opportunities results in less patients accessing primary care and MORE accessing emergency and specialty facilities, costing the system more money in an already tight environment given the Medicaid unwind, inflation and other influences of social drivers of health.

Why retain COFM family physician resident training funding?

- In such a challenging budget year, retaining the federal match for physician training provides alleviation of some of the burden on the state.
- Family medicine resident physicians see approximately 45,000 individual Medicaid patients each year, impacting access to care for our most vulnerable.
- COFM engages with over 2,200 medical students nationally to promote residency training in Colorado. Family Medicine residency programs graduate 83 family medicine residents annually on average, about 2/3s of whom stay in Colorado and 40+% of those choose to practice in rural and/or underserved communities.
- The COFM purposefully pursues opportunities to increase the number of family physicians training in Colorado.
- The University of Northern Colorado medical school supported by the state last year is required for accreditation to pursue residency training slots for one third of its enrolled students, or 45 slots, in addition to slots already available.

- Denver Community Health Services-Montbello Clinic (FHQC) is the newest of Colorado's family medicine residencies and will train 12 physicians annually, provide care to over 10,000 patients and provide over 30,000 patient visits when the full cohort is recruited.
- Over 70% of residents remain within 70 miles of where they train to practice medicine.
- Two thirds of patients receiving care from family medicine physicians and resident physicians in training are Medicaid or Medicare members or are uninsured; Family medicine residency program physicians serve as safety net providers.
- Of family medicine physicians with active licenses in Colorado, over ½ are graduates of Colorado programs, accounting for 1/3 of the primary care providers in the state.
- Federally qualified health centers are experiencing rarely seen challenges recently; family medicine residents help sustain the workforce with over a quarter choosing to practice in underserved settings.

COFM funding aids in closing access and workforce gaps across the state.

These funds are valuable to the overall success of the Commission and will allow the programs to enhance their efforts toward meeting statutory requirements and the mission of the Commission through: Supplementing current state support for training family physicians which will help alleviate some of the burden to sponsoring institutions and systems of training residents.

• Supplementing support for recruiting costs which have increased in the form of travel to medical school residency recruiting events, hosting activities and events, and promotional activity including sponsorship and exhibits.

• The current cost of training residents has increased from $150,000 to approximately $180,000 each since COFM funding first received state support (https://journals.stfm.org/familymedicine/2018/february/pauwels-2017-0230/) Although it was never the intent that the state would fully support these programs (the state annually contributes between three and four percent of the cost of training), funding provided helps defray costs to sponsoring institutions, which typically experience a loss, in training family medicine residents.

For example, one program has received permission to increase by 3 (14%) the number of family medicine resident physicians trained each year. These funds will assist to defray the cost of training those new residents.

VALUE OF FAMILY MEDICINE RESIDENCY PROGRAMS TO COLORADO

Shortage of primary care physicians

- 2020 County Health Rankings identify 17 counties with a shortage of primary care physicians (PCPs) in Colorado. Of those, half have only one or two PCPs, leaving little room for transition of the physician(s) from the county, which according to HRSA Area Health resources Files, has already occurred in several counties.
- In addition, 10 of the 17 have an uninsured population of 10+%.

- The St. Joseph's program in downtown Denver sees over 40% uninsured patients, and 32% Medicaid
- St. Joe's recently received a grant from Colorado Access to support a Community Health Worker to enhance diabetes care for its patient population
- A rural training track resident from the Alamosa program will be remaining in the community practicing family medicine and also doing endoscopies
- St. Mary's (Grand Junction) program has been asked by the local Medicaid office to care for refugees from Afghanistan through their clinic and family medicine resident physicians

- Finally of those 17 counties, 13 are directly served through the family medicine residency physicians in primary programs, rural rotations, and/or rural training track programs. All told, Colorado family medicine resident physicians touch patients in over 2/3rds of Colorado counties.

Colorado's family medicine residencies help fill the gap

- There are currently 10 family medicine residency programs in Colorado, due to the opening of the Denver Community Health Services-Montbello Clinic program start up in the summer of 2024.
- Programs are independent of one another but collaborate through the Commission on Family Medicine (COFM).

- Historically from 2010 through 2022 about 20% of family medicine resident physicians come from Colorado medical schools (University of Colorado and Rocky Vista University) and over 50% stay to practice in Colorado.
- Over 40% of graduates who stay in the state practice in rural or underserved areas, it was 61% in 2022 with 16% in rural and 22% in urban underserved.
- The residency clinics are part of Colorado's health care safety net. In 2024:
- Over 100,000 Coloradans received health care in family medicine clinics.
- 67+% of patients were Medicaid (44%) or Medicare (16%) or uninsured (7%).

Strategies to encourage family medicine residents to practice in rural Colorado

- COFM requires a one-month rural rotation for all

family medicine resident physicians.

- COFM supports rural training tracks (RTTs) in Alamosa, Fort Morgan, Sterling, and Wray. Residents live and train in the rural community in years 2 & 3 of residency.
    - COFM collaborates with rural training programs at CU Medical School and Rocky Vista University to create a training pipeline for graduates.
- COFM works with several state partners to enhance access to care including the Rural Health Center, CDPHE Primary Care Office, CO Academy of Family Physicians, and the Colorado Hospital Association, among others.

Funding the Family Medicine Residency

- Expenses for training family physicians are paid by the patient revenue, federal Medicare GME funds, the sponsoring hospitals, health systems and the Colorado General Assembly.
- The Colorado General Assembly provides funds to expand the number of family physicians being trained and place them in areas of highest need: rural and underserved areas. These funds are critical to the success of the Commission as they supplement the sponsoring institution support, show state investment in addressing access issues, and allow for investment in enhancing programs not otherwise available to them.
- State funds are matched by federal Medicaid dollars, effectively doubling the investment.

Family medicine training in Colorado

- Dual mission of training physicians and exemplary, direct care.
- Residents complete 3 years of training prior to going into practice.
- Our programs are sought after for our commitment to full scope, broad spectrum practice.
- Colorado requires one-month rural experience in addition to standard requirements.
- Residency Clinics serve as safety net care access (67+% Medicare, Medicaid and uninsured).

Support through State funding is increasing our number of primary care physicians

Sterling Regional Medical Center utilizes its rural training track funds along with its rural health clinic, OB physician and Family Medicine OB trained physicians to enhance maternity care throughout the region. Collaboration with the rural health clinic, telehealth support & the community at large also assist in the program's success.

- An average, over time, of 60% of residents stay in the state.
- Almost half on average stay in Colorado practicing in rural or urban underserved communities.
- Rural training programs (2014 fund start) add 6 graduates annually.
- Additional training positions (2015) add 5 graduates annually.
- Funds to expand residency training are long-term investments requiring sustained support.

Retention of graduates

- 83 total graduates in 2023.
- 61% of this year's graduates stayed in Colorado.
- 43% of those in Colorado practice in rural/underserved areas.
- 52% of the active family physician licenses in Colorado are held by COFM graduates.

Timeline of increasing the number of residents in family medicine programs:

CO Residency Program Base Support	2019/20	2020/21	2021/22	2022/23	2023/24
Total # of Residents*	247	265	258	260	**244**
Total # of Graduates*	82	81	85	83	**84**
Cost per Resident**	$359,387	$366,346	368,911	384,383	**$414,988**
State Support per Resident***	$13,523	$18,758	$12,946	12,847	**$13,689**
% Support from State***	3.7%	3.6%	3.5%	3.3%	**3.3%**

Total Number of Residents/Graduates: The table above does not include resident physicians training at Denver Health (DH), a training track of the UC Family Medicine Residency Program that does not qualify for State/COFM funding. The DH track includes 15 residents, bringing the total of family medicine residents training in Colorado to 260, 87 of whom are expected to graduate in June of 2024.

**To calculate the cost to train a family medicine resident, we obtain financial data from each residency program. The information reported by the programs includes the costs to support the educational components of residency training and clinical costs to operate a full-scope family medicine practice, inclusive of the costs of clinical and non-clinical staff, overhead, operations, etc. These costs are included because the clinical setting is central to training a family physician. The calculation of expenses is not standardized across programs. Some sponsoring hospitals allocate all operating costs to the residency. Other hospitals, however, do not include in their residency operating budgets such items as rent, utilities, IT services, security services, and human resources.

***State support per resident is calculated by dividing the *base funding* from the state by the number of residents in training. During FY 2022-23, the residency programs reported spending 99,939,559 for training 260 residents (DH residents are not included in this calculation). The % support from the state represents the proportion of the residencies' total expenses that is paid by *base funding*.

Benefits of the Commission

The Commission fosters collaboration among the independent programs:

- Increases the placement of graduates in rural and underserved locations.
- Improves quality of all the programs.
- Allows for efficiencies in programming and recruiting medical students.
- Ensures residents train in advanced primary care settings.

Challenges facing family medicine physician training

The Colorado Health Institute puts it well in their 2017 report *"Primary Care Workforce: A Study of Regional Disparities*" – "Investing in the workforce pipeline and creating local training opportunities will be important. It is not realistic to expect patients to commute great distances for care...Colorado's current workforce generally reflects the fee-for-service payment system, which creates incentives to provide as many medical services as possible and reimburses nonprimary care clinicians at higher rates than their primary care counterparts."

Delivering exceptional family medicine physicians to our most under-resourced areas is not without its challenges. Family medicine physicians do not choose family medicine because it is the most lucrative medical discipline. These family physicians love the interaction they have with patients, their families, and their communities, they strive to make a difference in their lives. Nevertheless, they have historically and continue to be one of the lowest paid of the medical specialties.

Other challenges also impact the family medicine specialty:

- Fewer Colorado family medicine residents are choosing to remain in Colorado due to:
  - Opportunities for spouses/significant others due to low unemployment rate.
  - Cost of housing in Colorado.
  - Full scope practice opportunities (in rural and underserved communities).
  - Colorado Medicaid/Medicare reimbursement rates are lower than nationally.
- Fewer medical students choosing family medicine as a specialty due to continued fallout from the pandemic and economic reasons (other specialties garner much higher salaries).
- Medical student interviews for residency continue to be virtual vs. in person inhibiting a medical student's opportunity to get a full picture of what 3 years of residency will be like.
- There have been changes in the scope of practice for graduating family physicians with more opportunities for full scope practice being limited and the trend of larger hospital systems to hire for urgent care/hospitalist roles vs. full scope, outpatient primary care.

NOTE: the federal Department of Health and Human Services recently published an issue brief describing the value of and challenges in the US primary care role https://www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf

Rural Training Tracks

The resident physicians who are trained in Colorado and whose programs participate with the Commission on Family Medicine continue to choose to practice in rural and underserved areas with physician graduates in rural practice up 75% prior to establishment of the Rural Training Track (RTT) program. An additional 20+% choose to practice in underserved urban communities where Medicaid members and people without insurance are more likely to reside.

Physician Workforce Pipeline in Action:
On the eastern plains, four rural training track trained physicians are practicing in Brush, Wray and Sterling after completing their residencies; evolving the rural practice pipeline for that region of the state.

-Information from Jeff Bacon, MD
-Chief Medical Officer, Sterling, CO

Colorado proudly hosts 4 rural training tracks through June of 2025:

***Alamosa *Fort Morgan *Sterling*Wray**

- The state generously supported start-up and development of three of these RTTs which graduated their first residents in 2019.
- Sustained state funding is necessary to augment what the host communities and institutions provide to support this training.
- This model has proven successes in increasing family medicine presence in rural communities.
- Wray (one of oldest in country) supports 1 resident, and the others support 2 residents per training year for years 2 and 3; year 1 is spent in urban "host program".
- Including Wray, the programs graduate 7 family physicians per year.
- RTTs are an example of state funds being used to train family physicians where we need them.

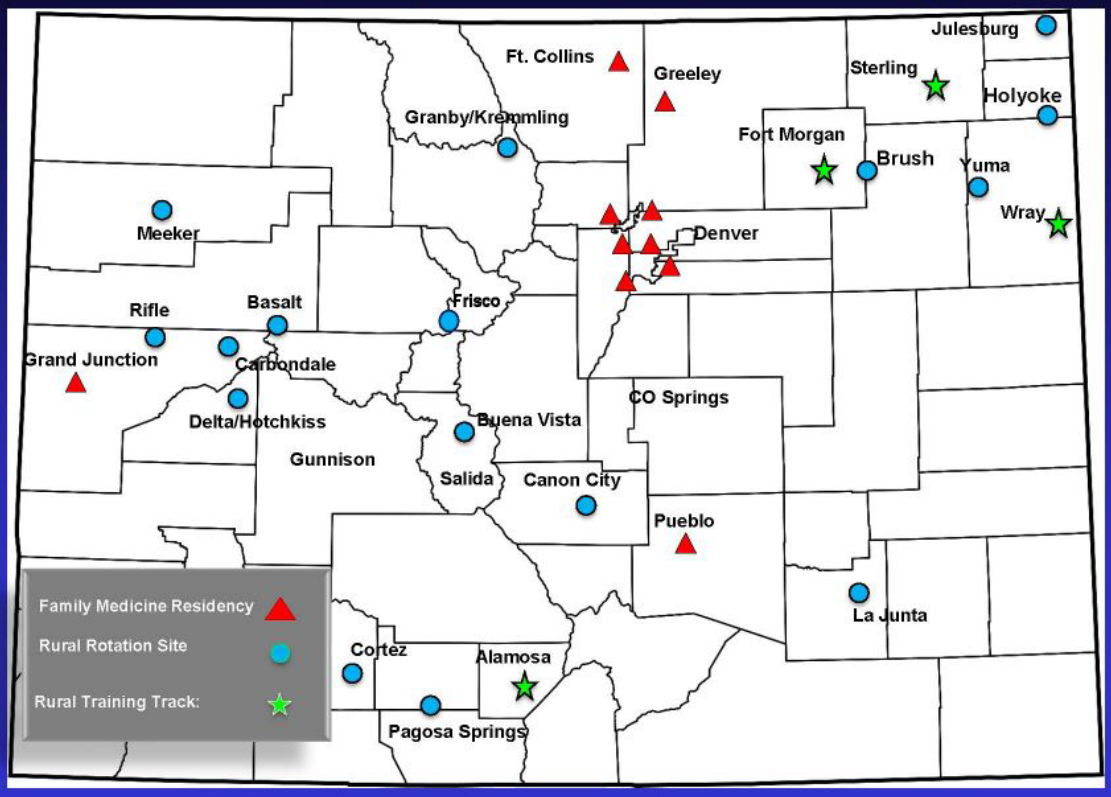
Background Information

Over the years, the legislature has requested that COFM develop programs and activities to support access to best practice primary care for the residents of Colorado. The General Assembly allocates funds annually to support the training of family physicians. Beginning in 2013, additional state funds have enabled the residency programs to expand the number of family physicians being trained and to place them in areas of highest need: rural and underserved communities.

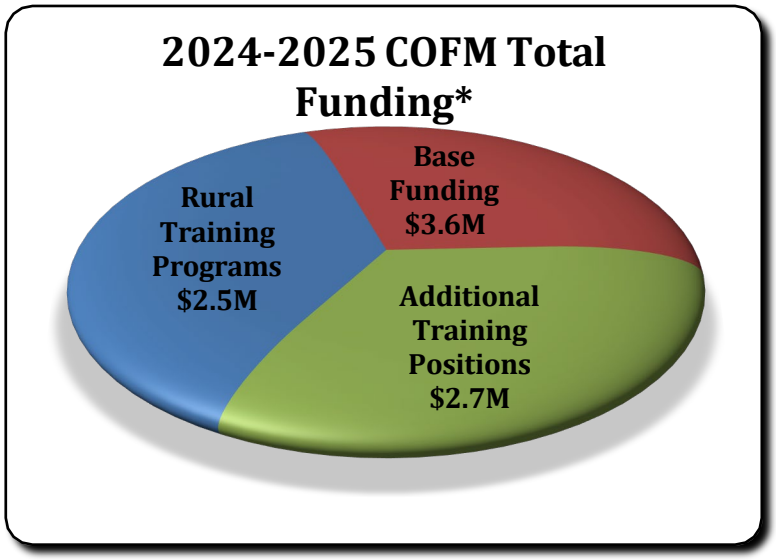
State funding is federally matched 50-50 ($4,745,085) – GF and FF through Medicaid Graduate Medical Education funds) This state funding support is crucial to the sustainability of the quality and comprehensive scope of the residency programs in Colorado to train family physicians (allocated to the Commission on Family Medicine) and falls into three categories noted below:

Base Funding ($1,801,458 GF)	Rural Training Track ($1,250,000 GF)	Added Resident Positions ($1,350,000 GF)
• Distributed from HCPF to residency programs • Supplements Medicare GME and other funding sources & patient revenue to defray expense of resident training • Recruitment of medical students into residency programs • Support resident exposure to rural practice experience • Enhance faculty and program leadership professional development • Provide collaboration, training and sharing of best practice among all residency programs • Supports care coordination and integrated care delivery across residency programs	• Initiated in SFY 2014-15 • Tracks established in Alamosa, Fort Morgan, Sterling • 6 potential graduates/year • Rural trained residents highly likely to practice in rural areas (approximately 60%) • Rural training requires sustained support and investment for training and retention • Rural "pipeline" is established through medical student recruitment from University of Colorado and Rocky Vista University and other medical schools across the country • Pipeline development expansion work	• Initiated in SFY 2015-16 • 5 programs added additional position each • Programs successfully graduated first cohort of 5 residents in 2017-18 • The program has successfully graduated 5 resident cohorts each year since 2017-18 • Residents commit to 3 years of practice in rural/underserved communities in exchange for loan repayment support • Loan repayment recipients currently practice in four different federally qualified health centers in the Denver Metro area and Lake County • Partner with CHSC to distribute awards and diversify workforce pool

Colorado Family Medicine Training Sites



RTT resident physicians see: • 50-60% Medicaid members • 10-25% Medicare members • 3-24% uninsured community members	Seventy resident physicians (on avg.) complete one-month rural rotations and a range from 150-300 visits, many with underserved patient populations each year.	Annually, rural track, community-based resident physicians provide: • Direct care to 10,000+ patients • About 21,000 patient visits • Multiple community projects & services

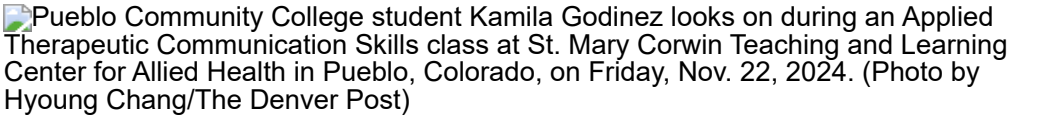


*State general funds ($4,745,085) are matched by federal Medicaid funds ($4,745,085) for $9,490,170 in total funds.

NEWS > HEALTH • News

Colorado doesn't have enough health care providers — even in Denver. What would it take to fix that?

State data shows no part of the state has enough primary care or mental health providers


Pueblo Community College student Kamila Godinez looks on during an Applied Therapeutic Communication Skills class at St. Mary Corwin Teaching and Learning Center for Allied Health in Pueblo, Colorado, on Friday, Nov. 22, 2024. (Photo by Hyoung Chang/The Denver Post)

Pueblo Community College student Kamila Godinez looks on during an Applied Therapeutic Communication Skills class at St. Mary Corwin Teaching and Learning Center for Allied Health in Pueblo, Colorado, on Friday, Nov. 22, 2024. (Photo by Hyoung Chang/The Denver Post)

By **MEG WINGERTER** | mwingerter@denverpost.com | The Denver Post

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Colorado has a serious shortage of primary care and mental health treatment statewide, but experts say some of the state's plans to address that could at least chip away at the problem.

Despite the perception that provider shortages are a rural problem, none of Colorado's 21 health regions — including Denver and the surrounding counties — have enough doctors, nurse practitioners and other medical workers to meet their residents' needs for care, according to data collected earlier this year by the Colorado Department of Public Health and Environment.

Single counties in the metro area are their own regions in the state's statistics, while less-populated parts of the state are grouped together. The state's data doesn't quantify how many more providers each region needs.

Colorado's best-served regions had enough providers to offer 81% of the primary care visits (in the San Luis Valley) and 72% of the mental health and addiction care (in Denver) that their populations needed, according to the state's data.

In parts of the high country and the Eastern Plains, the available appointments met one-fifth or less of the need for both types of care.

States can sometimes recruit doctors and other providers from areas that have a greater abundance, but that strategy is expensive, said Joshua Gottlieb, an economist at University of Chicago who has studied health care markets.

Ultimately, states need to either increase the supply of providers, or come up with creative ways to get more out of each one they have, such as having a doctor oversee nurses and technicians who do most of the hands-on care, he said.

"I don't think we have, as a society, explored how far we can push that," Gottlieb said.

Colorado has taken steps since the pandemic to increase its supply of providers, including:

- Appropriating almost $247 million in the most recent legislative session for colleges to expand their health care programs, including the creation of a new medical school at University of Northern Colorado
- Paying for classes and materials for community college students going into one of 14 health care careers that require two years of training or less, through the Care Forward Colorado program
- Creating "stackable" micro-credentials that allow students to quickly start working in the

Only the Care Forward Colorado program, which started in 2022, has some early results, which show about 5,600 people have participated, but only two in five have graduated. That rate is still an improvement over students working toward the same certificates who didn't receive Care Forward funding, though: less than one in four of them had graduated at the time of the evaluation. Others may graduate in the coming year.

A spokesperson for Gov. Jared Polis' office said the state is on the right track to fulfilling its health care workforce needs.

"We are saving people money, breaking down barriers to education and training, and developing a stronger workforce to fill in demand jobs and power Colorado's economy now and in the future," the governor's office said in a statement.

Combating shortages is a long-term proposition, to say the least.

Nationwide, almost three-quarters of federally defined health professional shortage areas remained in shortage 10 years after they received that designation, which opened up higher reimbursement rates and loan forgiveness options to physicians willing to work there. (The federal designation only counts physicians and deems an area to have a shortage if the ratio of residents to doctors is above a cutoff, while the state's numbers include other types of providers.)

Back in the 1980s and '90s, the country expected an oversupply of physicians, and medical schools cut back in response, said Shoshana Weissman, a fellow at the think tank R Street Institute. That set up the current situation, where essentially all states have shortages somewhere, she said.

Colorado has taken some important steps, such as allowing physician associates to practice without a doctor's supervision, Weissman said. The state could do more, though, including making it easier for immigrants who were providers in their home countries to find suitable jobs here and allowing pharmacists to provide more routine health services, she said.

"Anything they're trained to do, they should be allowed to do," she said.

Behavioral health department chair Callico Jones, left, teaches an Applied Therapeutic Communication Skills class to Pueblo Community College students at St. Mary Corwin Teaching and Learning Center for Allied Health in Pueblo, Colorado, on Friday, Nov. 22, 2024. (Photo by Hyoung Chang/The Denver Post)

The state also is trying to bring more people into the behavioral health workforce via "micro-credentials" that let them do entry-level work in mental health and addiction treatment, sometimes after as few as two classes.

Callico Jones, chair of behavioral health at Pueblo Community College, said students have the option of gradually stacking the micro-credentials until they earn a certificate, and then of building on that for a degree in a behavioral health field. Students who've completed the micro-credentials typically handle tasks such as helping patients find resources, which allows clinicians to focus on providing treatment, she said.

Pueblo Community College is one of seven offering five possible micro-credentials. About 100 students are enrolled in the college's behavioral health programs, which also include certificates and an associate's degree.

While some people in the field are leery of graduates who are taking the new path, it marks a return to the tradition of apprenticeship, since their students will work under licensed clinicians, Jones said. And given the "dire straits" of Colorado's health workforce, any new professionals will help, she said.

"Before higher education existed, people learned by doing," she said.

Little research on what works

States have tried a variety of strategies to increase their health care workforces, but they

The National Health Service Corps has the most data behind it, and it shows that most people don't stay in the areas where they served their stint to get loan forgiveness more than five years, she said.

Last's review of the available studies found each behavioral health provider participating in the corps gave about 1,300 visits per year that the centers where they worked couldn't have offered otherwise. Only about one-third stayed in the shortage area where they worked after their service time ended, though.

Whether that marks a success in temporarily increasing access or a failure to address shortages in the long term depends on your viewpoint, Last said. While the federal government hasn't collected much data on why providers leave, incomes tend to be lower in shortage areas and workloads tend to be higher, she said.

"You need to have a bigger carrot" to convince people to stay long-term, she said.

Most of the federal health workforce programs focus on loan forgiveness, but states might have more success if they reduced the cost of getting an education in the first place, via scholarships, Last said.

"A lot of people can't afford college. A lot of people can't afford graduate education," she said.

When UNC's new osteopathic medicine school is up and running, one of its goals is to work with K-12 schools and local health care providers to create "pipeline" programs that gradually expose kids to health careers, said Dr. Beth Longenecker, the school's first dean.

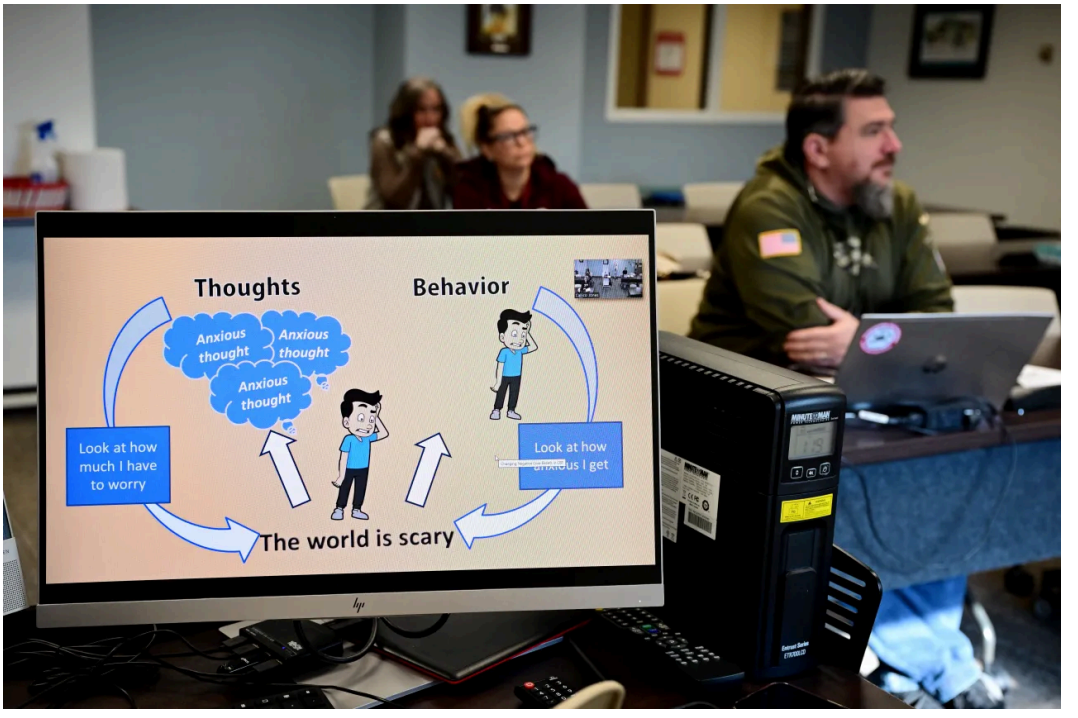
Osteopathic doctors, or DOs, learn how to manipulate the muscles and bones, in addition to prescribing medications and performing conventional procedures. While DOs can work in any medical specialty, they tend to pursue primary care because of the field's emphasis on looking at patients' wellbeing holistically.

Educating more primary care providers and people willing to work in underserved areas were two of the top reasons funders in Colorado got behind a new medical school, Longenecker said.

"I love the fact that the focus is, how do we recruit students who wouldn't consider going to medical school," she said.

The osteopathic medicine school also plans to offer a rural medicine track and set up rotations for students to train at least part-time in federally qualified health centers and in rural and frontier counties, Longenecker said. If they can find the start-up funds, they have the goal of helping providers create 45 residency slots over the next five years, she said.

"If you can have exposure where you can see the impact on a rural community, I think that will inspire our students," she said.



Pueblo Community College students are taking an Applied Therapeutic Communication Skills class at St. Mary Corwin Teaching and Learning Center for Allied Health in Pueblo, Colorad,o on Friday, Nov. 22, 2024. (Photo by Hyoung Chang/The Denver Post)

Where new doctors complete their residency can be at least as important as where they attend medical school, with those who train in underserved areas more likely to practice there.

Residency lasts at least three years, which is enough time that trainees become part of a community and consider staying, said Brianna Lombardi, director of the University of North Carolina Behavioral Health Workforce Research Center. The programs aren't easy to set up, though, and rural hospitals likely would need significant federal support to make it happen, she said.

"It's really easy for the academic centers to train a lot of people, because that's how they're set up," she said.

Increasing the number of medical graduates is only part of the solution, though, said Dr. Robert Cain, president and CEO of the American Association of Colleges of Osteopathic Medicine.

More young doctors need the option to complete their residencies in rural areas, but small hospitals may not be able to handle the upfront cost, which can exceed $150,000 for each resident, he said. The federal government reimburses hospitals for training expenses, but only after the first three years.

And none of that is a substitute for increasing pay and respect for primary care providers, Cain said.

"What we haven't done is resource primary care and promote primary care so people want to go into it," he said.

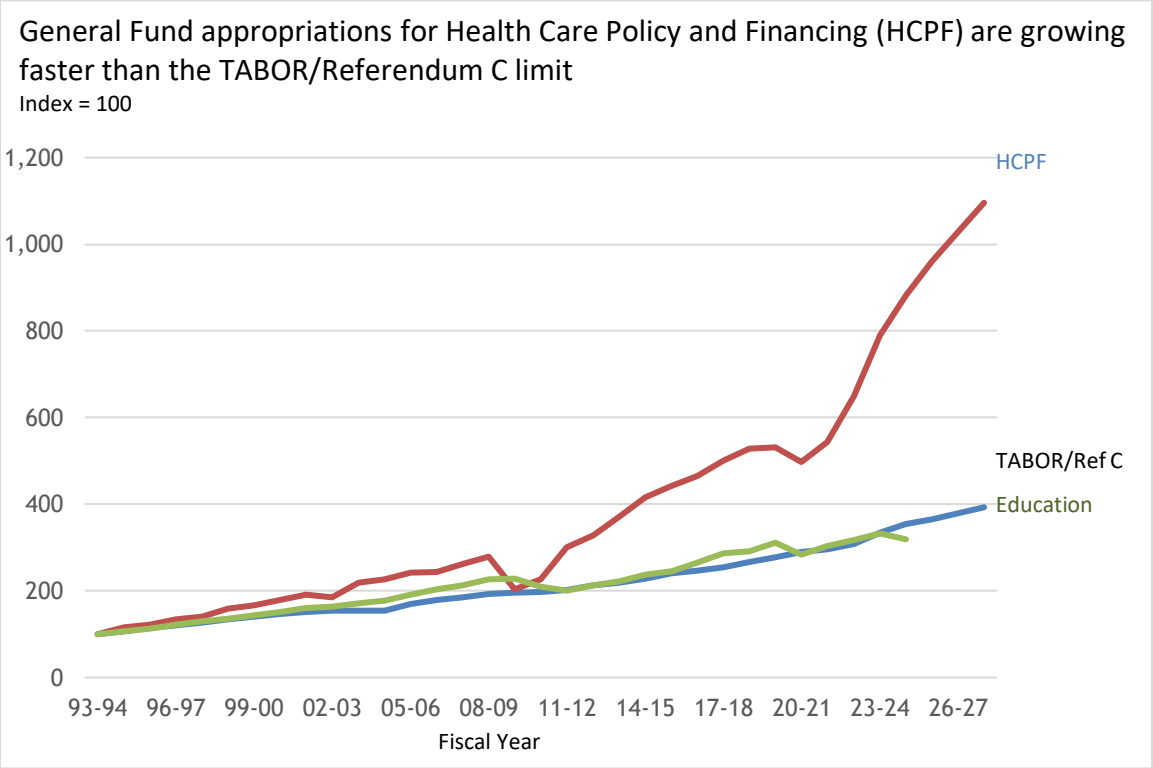
DEPARTMENT DISCUSSION QUESTIONS

GROWTH AND SUSTAINABILITY

1. **[Sen. Bridges/Sen. Kirkmeyer] Please project the Department's total General Fund expenditures through FY 2027-28. Use this information to extend the graphic provided by the JBC staff (page 47 of the briefing) comparing the growth of the Department to the TABOR/Ref C limit.**

RESPONSE

HCPF included the projected TABOR/Ref C limit based on OSPB's September revenue forecast and projected General Fund expenditures for HCPF through FY 2027-28 in the updated chart below:



2. **[Rep. Bird] Where is HCPF seeing the biggest changes in service utilization, after removing changes in per capita costs attributable to the end of continuous eligibility? What services and populations are driving increased costs?**

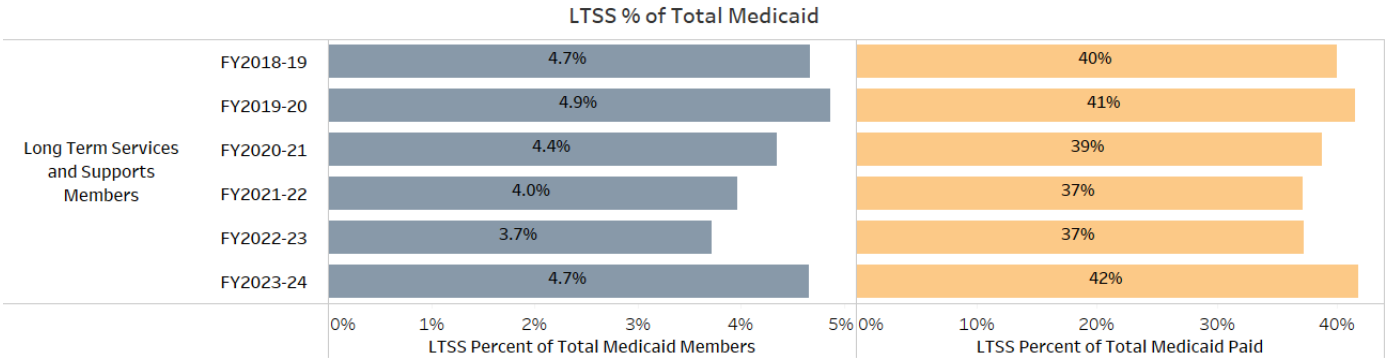
RESPONSE

HCPF saw the largest increases in service utilization as a result of per capita cost changes attributable to the PHE unwind. For example, acute care services per capita costs overall rose by 26.2% over FY 2022-23 into FY 2023-24 while caseload dropped by 19.2% over the same

time period. This resulted in the largest driver in HCPF's over expenditure and change in forecasted costs. Overall Acute Care expenditure rose by $115.1 million year-over-year or 2% despite significant enrollment declines. Most acute care services remained flat or increased; for example, hospital expenditure decreased 1% or by $17.2 million from FY 2022-23 to FY 2023-24, net drug expenditure dropped by 0.1% or $0.6 million, and physician service expenditure rose by 4.2% or $49.6 million.

Behavioral Health saw a decrease in expenditures year over year from FY 2022-23 into FY 2023-24 because of the continuous coverage unwind. While actual expenditure decreased for HCPF as there were less capitations paid, the underlying acuity of members was increasing as members on average accessed more behavioral health services. In addition, SB 22-156 "Removal of Prior Authorization for Psychotherapy Services" contributed to an increase of $38.8 million due to higher utilization of psychotherapy services. These changes led to HCPF forecasting significant growth in the capitation rates paid, contributing to an increase of $263 million total funds, including $68 million General Fund, from FY 2023-24 to FY 2025-26.

Outside of the increases in acute care and behavioral health per capita costs, HCPF is seeing increases in several service areas across different populations due to rate increases approved by the General Assembly and increases in utilization. There were increases in services for members living with disabilities including waiver services, long-term home health, and other long-term care options like the program for all-inclusive care for the elderly. Since the end of the PHE, the demographics of the members enrolled in Medicaid have shifted to be more weighted towards members utilizing these services, as shown in the chart below:



HCPF has seen a large increase in costs due to the ongoing need to keep the direct care workforce wages in line with local minimum wage requirements. HCPF, in partnership with the Joint Budget Committee, has increased rates for the direct care workforce several times over the last five years to keep up with Denver minimum wage and statewide minimum wage, in many cases using ARPA funds for the state share for the initial year of the increase. From FY 2021-22 to FY 2023-24, the JBC has approved across the board rate increases, targeted adjustments to account for minimum wage increases, and other targeted rate adjustments that impact community-based care options totaling approximately $683 million. This has been a necessary investment to ensure the workforce is available to allow members continued access to services but has driven a significant fiscal impact over the years.

HCPF is seeing increases in long-term home health due to the temporary pause for prior authorization requirements, resulting in increases in the number of people accessing services and the average number of services a member is receiving. From FY 2020-21 to FY 2023-24, HCPF has seen an increase of $204.9 million in long-term home health services, which are provided by nurses or certified nursing assistants, which is an increase of approximately 46.0% over that timeframe. Prior authorization reviews will be turned back on in July of 2025 to ensure appropriate utilization of services.

HCPF has also seen increases in utilization for In Home Services and Supports (IHSS). IHSS is a service delivery option that allows members on waivers to receive personal care, homemaker, and health maintenance activities in their home setting. In response to the ongoing need to provide more access to services in home and community-based settings, and to save money on services, HCPF, in partnership with the Joint Budget Committee, has pursued SB 23-289 "Community First Choice Medicaid Benefit." This legislation allows HCPF to secure an additional 6 percentage points in the federal match rate for services such as Personal Care, Homemaker, and Health Maintenance, which make up the IHSS delivery model, by changing the authority by which we are granted federal approval. This shift is projected to generate General Fund savings starting in FY 2025-26, providing a return on the state's significant investments in these essential services.

3. **[Rep. Bird] Is the Department's growth sustainable? If so, how? If not, what is the solution?**

RESPONSE

Since 2000, U.S. medical inflation has increased by 121.3%, while prices for all goods and services rose by 86.1% in the same time period. Despite some recent fluctuation, medical inflation continues to outpace growth in other goods and services. U.S. medical care services Consumer Price Index (CPI) rose 2.0% in 2019, 5.1% in 2020, 0.4% in 2021, 4.5% in 2022 and 0.1% in 2023. In June 2024, medical care increased by 3.3% from the previous year and overall annual inflation grew by 3% (Source: Kaiser Family Foundation analysis of Bureau of Labor Statistics and Bureau of Economic Analysis data August 2024[1]).

Medical inflation is driven by a number of factors. **Factors heavily influenced by state policies include: (a) provider rate increases and (b) utilization of services.**

(a) Provider reimbursement rates - provider rates have increased dramatically, both through across-the-board and targeted increases, over the last few years, as noted in the below graphics below. These were concurrent with massive, one-time federal stimulus dollars provided to states, which have ended. These increases from FY 2021-22 – FY 2024-25 total 9.5% but compound to a 10% increase across impacted providers, thereby having a direct and meaningful impact on the base cost of the Medicaid program. Previous to these large stimulus

[1] www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/

related increases, the across-the-board increases totaled 6.27% for FY 2010-11 through FY 2019-20 (compounded), with an averaging annual increase of 0.62%.

Fiscal Year	Across-the-Board Increase
FY 2010-11	-1.00%
FY 2011-12	-0.75%
FY 2012-13	0.00%
FY 2013-14	2.00%
FY 2014-15	2.00%
FY 2015-16	0.50%
FY 2016-17	0.00%
FY 2017-18	1.40%
FY 2018-19	1.00%
FY 2019-20	1.00%
FY 2020-21	-1.00%
FY 2021-22	2.50%
FY 2022-23	2.00%
FY 2023-24	3.00%
FY 2024-25	2.00%

During the recent years of one-time federal stimulus dollars (FY 2021-22 – FY 2024-25), the General Assembly provided $434.5 million total funds in targeted rate increases, including $149.3 million General Fund, reflecting an average of $108.6 million total funds and $37.32 General Fund each year. These increases also established a new baseline, driving Medicaid trend. These targeted rate increases compare to a prepandemic average targeted rate increase of $20.0 million total funds, including $9.4 million General Fund. A return to

prepandemic, prefederal stimulus norms would better manage Medicaid trends, after the state adjusts to the increases already implemented.

Amount Funded for New Targeted Rate Adjustments Through Long Bill

Fiscal Year	Total Funds	General Fund
FY 2018-19	$24,591,832	$11,565,718
FY 2019-20	$15,457,091	$7,237,879
FY 2020-21	$1,905,204	$1,389,576
FY 2021-22	($4,204,227)	$2,662,375
FY 2022-23	$111,743,414	$42,740,454
FY 2023-24	$128,810,841	$42,357,335
FY 2024-25	$198,146,802	$61,534,447
Includes rate increases from the rate review process, HCBS base wage increases, and other targeted rate adjustments		

(b) **Service utilization** is further driven by access, the health of the covered population (acuity), and utilization review programs in effect or impeded by state policies. 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.

Network Access. The chart below illustrates the tremendous increase in Medicaid network providers, which is increasing access to care for Medicaid members and therefore enabling increased utilization.

Year Ending	9/30/2018	9/30/2019	9/30/2020	9/30/2021	9/30/2022	9/30/2023	9/30/2024	Increase (2018-2024)	% Increase (2018 - 2024)
Medicaid Provider Network Enrollment	63,697	73,378	81,942	88,794	100,012	111,243	108,646	70.6%	44,949

Source: 2018-Sept 2020, calculated from Total New Enrollment Apps - Voluntary Disenrollments. 9/30/21 and forward - monthly Provider Churn report

Utilization Review. When bills are passed that prohibit HCPF from performing medical necessity and utilization review, Medicaid trends increase because HCPF is prevented from reviewing medical necessity and whether the right care is provided in the right setting to drive improved member outcomes and more efficient Medicaid cost trends. Unlike

commercial insurance carriers and health plans, Medicaid does not have a profit interest; savings is retained by the General Fund. Further, Medicaid utilization management has not had near the same level of provider or member complaints. (Beyond utilization management is the provider Recovery Audit Contractor (RAC) program, which is not a prior authorization related program but rather a post payment, third party review). Utilization programs for consideration include:

- Allow HCPF to reengage on outpatient Behavioral Health utilization review to drive down the increases in Medicaid trends occurring since preauthorization utilization management was lifted last year.
- HCPF is now scheduling the reinstatement of Long-Term Home Health Prior Authorizations at the close of the Maintenance of Effort (MOE) requirement under the American Rescue Plan Act (ARPA).
- Prior Authorizations were fully reinstated for the Private Duty Nursing (PDN) benefit to assure appropriate medical necessity reviews for approvals.

The Importance of Funding the Accountable Care Collaborative (ACC) Phase III FY 2025-26 R-6 Budget Request. As background, the efficient use of health care services is further driven by the overall infrastructure and advances within the benefit program; for Colorado Medicaid, our main delivery system is the ACC. Phase III of the ACC goes into effect July 1, 2025, and includes programs to more effectively control cost trends while increasing focus on member outcomes, quality and access to care. As an example, features associated with ACC Phase III include:

- Provider payment methodologies to incentive the use of the provider tools and other behaviors that improve quality outcomes and better control costs;
- eConsults to cost effectively increase access to specialty care through the primary care provider, while reducing inappropriate specialty care referrals;
- Increase prescriber tool OpiSafe prescription safety and affordability modules available to prescribers to help them be part of the prescription drug affordability solution;
- CO Social Health Information Exchange (CO-SHIE) to refer members to whole person medical, social and community services and supports, which help to mitigate condition escalation and control Medicaid trends;
- Infrastructure modernization for primary care providers in rural health clinics that enable them to better identify high risk and high acuity patients and better manage patient care and costs;
- Advanced analytics to identify and better support/care for members with higher needs and acuity risk, supporting Medicaid trend control;
- Condition management and case management programs that focus on care for acute or at risk members (i.e., prenatal, diabetes, complex patients, cancer screenings and more);
- Member incentives to engage in Medicaid programs, and more.
- HCPF has identified an area of opportunity to further bend the cost curve, building on previous ACC cost saving efforts, by reducing the inpatient readmission rate. Currently,

Colorado Medicaid's readmission rate performs at the 33rd percentile nationally. The FY 2025-26 R-6 request will provide funding for RAEs to increase their care coordination staff and use of evidence-based models, as detailed below, to improve readmission rates, thereby lowering hospital expenditures.

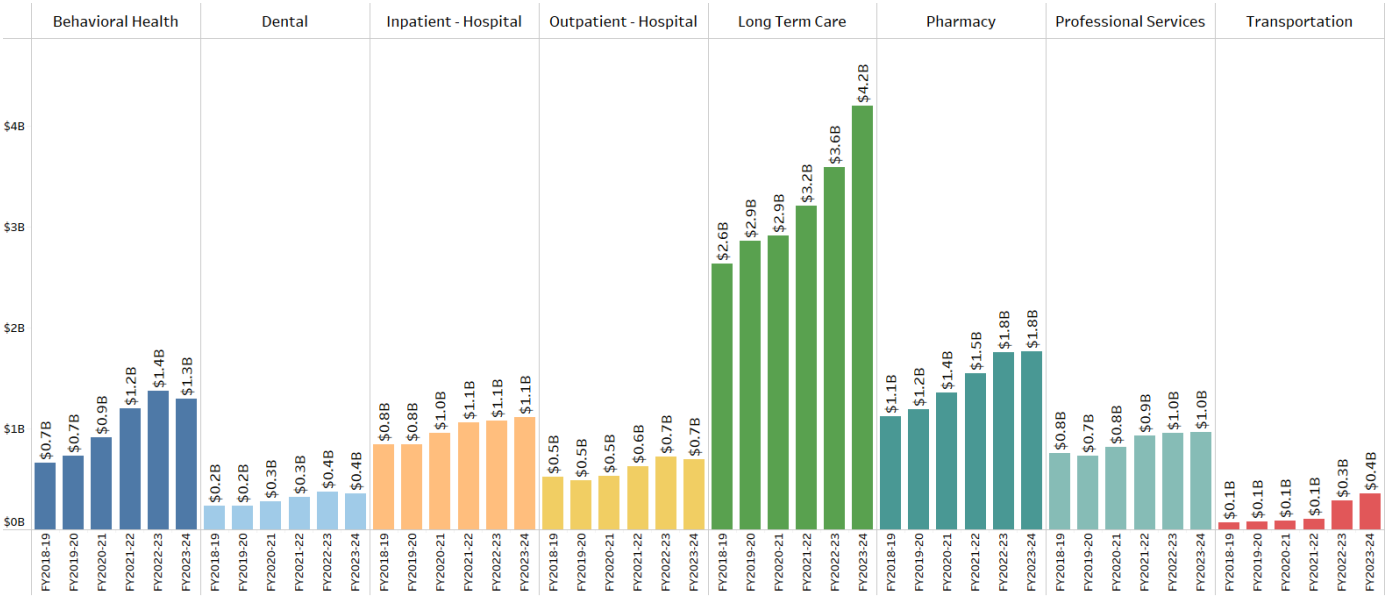
Not implementing the ACC Phase III budget request reduces the state's ability to battle Medicaid trends in order to protect member benefits, provider reimbursements and eligibility access, while increasing quality and closing disparities. Further details on the importance of approving the FY 2025-26 R-6, "Accountable Care Collaborative Phase III" is below. Specialty drugs and customized medicine are driving dramatic increases in prescription drug costs. Less than 2% of drugs prescribed for patients covered by Medicaid and Commercial coverage are so expensive, they are driving more than 50% of prescription drug costs (for Medicaid 1.73% of pharmacy claims are driving 52.16% of pharmacy spend). It is critical that utilization management programs and coverage policies enable HCPF to control Medicaid's $1+ billion prescription drug spend, half of which is being driven by high-cost specialty drugs.

A less controllable factor is the acuity of our population of people with disabilities who are accessing Long-Term Services and Supports (LTSS). 86% of the LTSS population has at least one chronic condition, compared to 28% of non-LTSS Medicaid members, and 37% have 5 or more chronic conditions (FY 2023-24 Medicaid Management Information System data). **While the acuity of the population is less controllable, proper utilization management better ensures appropriate access to the right waivers and supports as well as the right care, in the right setting, at the right price, which is absolutely critical to controlling Medicaid LTSS trends.**

Item	CHP+	Total Medicaid	Medicaid LTSS	Medicaid Non-LTSS
Enrollment	68,564	1.4 million	65,823	1.2 million
Total Paid	$189 million	$12.3 billion	$5.1 billion	$6.9 billion
PMPM	$225	$727	$6,514	$471

Reductions made to the CHP+ program will not impact overall trend, plus CHP+ also has a higher federal matching rate. The CHP+ program covers children and pregnant people whose households earn too much to qualify for Medicaid but not enough to afford other health insurance coverage. This safety net program helps keep Coloradans covered while avoiding a more severe "cliff effect" when families are rising out of poverty and earn too much to qualify for Medicaid.

Sustainability efforts include monitoring cost trends and trends by benefit on a monthly basis. HCPF's expenditures grew 34% from FY 2020-21 to FY 2023-24. For comparison purposes, HCPF covered 1.4M lives in FY 2020-21 and in FY 2023-24. The top four cost categories are inpatient long-term services and supports (LTSS), behavioral health, pharmacy, hospital as noted in the chart below.



Strategies to address costs in each of these benefit categories are detailed below:

Long-Term Services and Supports:

The main three cost drivers in LTSS are provider rate increases (50%), enrollment increases (11%), and utilization changes (39%). Cost drivers and strategies for LTSS are addressed below. Additional information is in the response to questions on LTSS trends (please see Questions 9-10, 13, 15).

As stated in previous responses to questions about LTSS cost trends, HCPF has seen an increase in the cost trend for Long-Term Service and Supports (LTSS). This trend has been increasing over time and is driven by increases in rates, enrollment, and utilization. In observing this trend, HCPF has been diligent and proactive in pursuing utilization management strategies to ensure that members access care that is most cost-effective in meeting their needs. The primary ways to control state costs related to LTSS are through utilization management and review, post payment review and audits, and leveraging opportunities to receive an enhanced federal match or federal funds supporting LTSS programs.

HCPF has implemented several efforts aimed at ensuring sustainability of LTSS programs, some of which include the requirement for prior authorization for all Home & Community-Based Services (HCBS) and residential services, including Intermediate Care Facilities (ICF) and the Hospital Back-Up (HBU) program. HCPF also reinstated the Prior Authorization Request requirement for the Private Duty Nursing (PDN) benefit, which had been paused for several years, to ensure medical necessity reviews were performed.

HCPF has also leveraged additional utilization management strategies for LTSS, understanding that costs have increased and that the state must be able to financially sustain these

programs for the future. To ensure the services billed for were delivered, HCPF implemented Electronic Visit Verification (EVV). Additionally, prior to being approved, HCPF requires that Program of All-Inclusive Care for the Elderly (PACE) organizations show their ability to operate without state support for the first several years of operation, ensuring financial solvency. PACE organizations must also develop enrollment and expansion plans that demonstrate thoughtful and planned growth trajectories. HCPF also performs Post Payment Reviews of claims submitted for waiver services as well as Targeted Case Management (TCM) claims submitted by each Case Management Agency (CMA) to identify any discrepancies in claims and conducts annual Nursing Facility Financial Audits. Each of these reviews can result in revenues returned. HCPF also conducts federally required subrecipient financial monitoring of all CMA contract administrative payments through quarterly analysis of all payments made to the CMAs to ensure payments are not made in error. This includes looking for possible overpayments such as duplicate payments and lack of appropriate approvals as well as a verification that payments were calculated correctly. Any identified over payments are recouped from the CMAs on the next month's payment cycle.

Finally, HCPF continues to pursue opportunities to leverage enhanced Federal Financial Participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) to decrease the impact on the state's General Fund. Currently, HCPF is the recipient of the Money Follows the Person (MFP) Federal Grant, which provides an enhanced FFP rate that results in 25% savings for the services offered by participating states that can be reinvested in additional community-based supports. Under this grant, some services are provided with 100% FFP. Additional ways that HCPF leverages enhanced federal match, include utilizing Quality Improvement Organizations (QIOs) for all utilization management review services, allowing HCPF to receive a 75% match for these services, and submitting Advanced Planning Documents (APDs) for system development and implementation, which allows HCPF to claim a 90% match for these activities.

In addition to the robust strategies outlined above, several others are in the process of being implemented, including:

1) Reinstating Long-Term Home Health (LTHH) Prior Authorization Request Requirement after the end of the Maintenance of Effort (MOE) requirement under the American Rescue Plan Act (ARPA).
2) Launching a new Skilled Single Nursing Assessment to be performed by a qualified nurse. The aim of the new assessment is to mitigate the risk of duplicative authorization across all three skilled care modalities while also streamlining and improving the process for members and controlling cost growth.
3) Implementing Community First Choice to generate state savings by receiving an enhanced 6% FFP rate on existing and new consumer-directed services in the State Plan. This is anticipated to save the state $40M annually after its second year of implementation.
4) The adoption of the new Colorado Single Assessment (CSA) and Person-Centered Budget Algorithm (PCBA); a normed referenced standardized assessment which will better ensure authorized HCBS services are based on need.

5) Implementation of a new Skilled Nursing Facility Reimbursement Methodology and Compliance Requirements focused on outcomes and providing underserved populations with care.

Inpatient Hospital (relates to FY 2025-26 R-6, "Accountable Care Collaborative Phase III"): As the Colorado Medicaid delivery system, ACC Phase III is a critical part of HCPF's efforts to change the cost growth trajectory of inpatient hospital expenditures. As opposed to cutting benefits or coverage for members, one of the key goals for ACC Phase III is to manage costs to protect member coverage and benefits and provider reimbursements. HCPF has identified an area of opportunity to further bend the cost curve, building on previous ACC cost saving efforts, by reducing the inpatient readmission rate. **Currently, Colorado Medicaid performs at about the 33rd percentile nationally – leaving significant room for improvement**. One strategy to improve our performance and impact the cost curve is to ensure Medicaid members receive follow-up care within 30 days after discharge from an inpatient stay or residential care. This type of transition of care (TOC) currently happens consistently about 65% of the time. HCPF has included a funding request (FY 2025-26 R-6, "Accountable Care Collaborative Phase III") to support the RAEs to hire staff that would target the 35% of members not receiving this type of follow-up care and reduce the inpatient readmission rate. The lack of follow-up visits after a major health care event, like an inpatient discharge, demonstrates a gap in care coordination that increases Medicaid expenditures when those members are readmitted for a hospital stay.[2]

Program investments, like ACC Phase III's enhanced care coordination requirements, have quantifiable cost growth reductions. The savings impact of North Carolina's transitional care program resulted in a 25% reduction in inpatient admissions, and up to 32% averted readmissions for the higher risk patients. We are not projecting as high of outcomes as seen in North Carolina because that program was brand new when implemented, whereas the ACC started in 2011. However, the specific interventions attributed to North Carolina's success have been added into the RAE Phase III contracts. New RAE performance expectations and pay-for-performance rewards have also been included to ensure performance targets are met. If the R6 budget request is not funded, the RAEs will not be able to increase their staff to realize this potential for savings.

Pharmacy/Prescription Drugs:

Pharmacy expenditures have been steadily increasing due to a combination of economic, regulatory, and market dynamics and one of the main factors driving these increases is the rising cost of specialty medications (usually cell and gene therapies) which account for less than 2% of our pharmacy claims and more than 50% of our pharmacy expenditures. To curb this, we are:

1) Increasing use of the prescriber tool affordability module. This is critical to address Medicaid spending on all drugs. Over 55% of providers already use the tool, which

[2] www.communitycarenc.org/sites/default/files/2018-07/transitional-care-cut-hospital-readmissions-north-carolina-medicaid-patients.pdf

provides doctors with insights into more cost-effective drug alternatives under Medicaid and enables quicker and easier prior authorizations when needed. It further mitigates barriers from members filling their prescriptions, improving compliance.

2) Entering into value-based contracting agreements with specialty drug manufacturers. To date, we have entered into 5 agreements. These agreements are intended to hold drug manufacturers accountable for the performance of their products (i.e., requiring additional rebates when the drugs fail to perform as marketed).
3) Monitoring drugs that manufacturers are researching and developing (i.e. the drug pipeline) to assess the estimated market release date and impact to our program. This research helps us to identify new opportunities for savings through contract negotiations and utilization management.
4) Engaging in multistate contracting opportunities, such as the CMMI Cell and Gene Therapy Access model to increase our leverage in high-cost drug negotiations. As background, most of the time, specialty drugs must be administered in the hospital or clinic setting so we have been steadily increasing our utilization management program for these types of drugs (also known as physician administered drugs). Since 2022 we have applied utilization management to over 40 physician administered drugs with an additional 10 drugs being added in 2024.
5) Proposing to increase the maximum allowable cost (MAC) discount to offset pharmacy costs on certain drugs for which the average acquisition cost (AAC) or National Average Drug Acquisition Cost (NADAC) are not available (FY 2025-26 R-15, "Pharmacy MAC"). Increasing the MAC discount will reduce pharmacy costs by more closely aligning pharmacy rates with prescription drug acquisition costs.
6) Leveraging our drug utilization review program to analyze quarterly claims data to identify opportunities for utilization management, inappropriate use, safety issues and waste.

Addressing pharmacy costs requires a multi-faceted approach involving regulators, manufacturers, payers, and consumers. While no single strategy will suffice, implementing a combination of these tools is assisting HCPF to slow the rise in drug expenditures while ensuring our members maintain access to life-saving medications.

Behavioral Health:

The increases in behavioral health expenditures can be attributed to four major areas: network improvement (more providers available), service expansion (more services available), greater access (higher utilization per person), and increased reimbursement (higher costs per service).

These four areas are explained in depth in the response to the questions on behavioral health forecast trends (please see Questions 21-22).

OFFICE OF COMMUNITY LIVING

4. **[Rep. Bird] Are HCBS waivers considered an entitlement by the federal government? Does the General Assembly have the authority to reduce the number of waiver slots?**

RESPONSE

While Medicaid is an entitlement program, the federal government dictates which benefits are considered 'mandatory' and which are considered 'optional.' Home and Community-Based Service (HCBS) waivers are considered optional programs that states may implement to provide individuals services in their home and community, rather than in an institution such as a nursing facility or hospital. With HCBS Waivers, an individual might meet the eligibility requirements but be unable to receive services as the maximum number of participants for that waiver has been met. For example, the HCBS-Developmental Disability (DD) waiver has a waiting list.

The General Assembly has the authority to reduce enrollment for HCBS waivers. Depending on the waiver reductions considered, an analysis as to the net fiscal impact would need to be completed, recognizing how care might shift to other covered services as well as the effective date of the implementation. If the General Assembly chooses to reduce the appropriation for the HCBS waiver programs, HCPF may not be able to implement it until July 1, 2026. This is because there is a Maintenance of Expenditures (MOE) requirement during the first year of implementation for Community First Choice, which was authorized under SB 23-239. Failing to meet the MOE requirements for CFC would risk program savings, estimated to save Colorado approximately $40 million.

5. **[Rep. Taggart] Does the State face any liability risks as a result of the waitlist for Adult Comprehensive waiver services? If so, please explain that risk.**

RESPONSE

Home and Community-Based Services (HCBS) waiver programs are not an entitlement, unlike traditional Medicaid services, which must be provided to all eligible individuals. Federal Medicaid rules allow states to cap the number of members served. Because of this federal flexibility, the state does not explicitly face any legal liability risks due to the waitlist for the HCBS-Developmental Disability (DD) waiver.

The HCBS-DD waiver is the only waiver in Colorado with a waitlist. This number may increase or decrease each year depending on legislative appropriations. It is important to note that decreasing the number of available HCBS-DD waiver slots would be complicated and may have a negative impact on members. If the waiver is at capacity and the enrollment cap is decreased due to appropriation changes, it would be necessary to decrease incrementally as members disenroll from the waiver. Once a member is enrolled on a waiver, the state may not deny a waiver-provided service for which the person has an assessed need.

While the provision of HCBS in Medicaid is not mandatory, HCBS waiver programs are widely recognized as a more inclusive and cost-effective way to support people with disabilities to thrive within their communities. The HCBS-DD waiver offers 24/7 support and, as such, is one of the most expensive HCBS programs Colorado offers. Because of this, HCPF has collaborated with stakeholders to ensure access to other services for people on the HCBS-DD waiver waiting list. Members can only be enrolled on one waiver at a time but may qualify for multiple waivers. Most members waiting for the HCBS-DD waiver are accessing other Medicaid

support. As reported in the November 2024 report to the General Assembly[3], at the time of the report, there were 3,038 members on the waiting list, with 91% of those members (2,765) receiving other Medicaid services and 71% (2,157) receiving other HCBS waiver services.

6. **[Sen. Amabile and Rep. Taggart] Please discuss the federal match that applies to the several HCBS waivers. Does it vary depending on the waiver and specific population served?**

RESPONSE

Pursuing federal policy options that offer additional federal match is a key strategy in dampening the General Fund impact from long-term services and supports expenditure. HCPF currently draws down a 50% federal match rate for Home and Community-Based Services (HCBS) waivers, regardless of the waiver or specific population served. Starting in FY 2025-26, HCPF will be able to draw down an additional 6 percentage points in the federal match rate for certain services that will shift from the HCBS waivers to the state plan through implementation of SB 23-289, "Community First Choice Medicaid Benefit." This will include Personal Care, Homemaker, Health Maintenance, and other services that are currently available to members enrolled in the HCBS waivers, projected to save the state around $40 million net General Fund starting in FY 2026-27.

HCPF was awarded a federal Money Follows the Person grant which provides a 75% federal match rate for existing services supporting a member transitioning to the community from an institutional setting. The additional 25% match rate is required to be set aside and invested in HCBS or transition supports. With this grant also comes the opportunity to pilot services supporting transitions from institutional settings, not already covered by Medicaid, at a 100% federal match rate.

7. **[Sen. Kirkmeyer] Has the Department applied for the CHRP eligibility waiver as directed by HB 24-1038 (High Acuity Youth)? When did the Department apply, or when does the Department expect to apply, and when does the Department expect to know the outcome of the application? What was the outcome of the application if known?**

RESPONSE

HCPF submitted an application to the Centers for Medicare and Medicaid Services (CMS) for the Children's Habilitation Residential Program (CHRP) waiver, as directed by HB 24-1038. The waiver application was submitted on Sept. 6, 2024, and was approved on Oct. 24, 2024. This waiver eligibility change will be effective Jan. 1, 2025.

8. **[Sen. Amabile] Does the Department have any preliminary caseload updates for FY 2025-26? If so, please provide those estimates.**

[3] hcpf.colorado.gov/sites/hcpf/files/HCPF%202023_24%20IDD%20Strategic%20Plan.pdf

RESPONSE

There are no preliminary updates to the FY 2025-26 forecast. HCPF monitors expenditure and caseload compared to the current appropriation and publishes that information monthly in response to Legislative Request for Information #1. HCPF staff will complete detailed analyses and projections for all Medicaid and CHP+ services using data through December 2024 to inform the forecast that will be submitted on Feb. 15, 2025.

LONG-TERM SERVICES AND SUPPORTS

9. **[Sen. Amabile] What explains the long-term trend of significant per capita cost increases for the elderly and people with disabilities? Are people more disabled? Are people struggling to access services and becoming more sick as a result?**

RESPONSE

The long-term trend of significant per capita cost increases for older adults and individuals with disabilities is driven by multiple factors, many of which are discussed in the response to question 10. In addition to the already outlined cost drivers, such as rate increases, enrollment growth, and utilization shifts, broader historical and structural contexts have shaped these trends.

People with complex needs are living longer- Advances in health care have contributed to the cost trend by enabling individuals to live longer, though not always healthier, lives. While average lifespans for men and women have increased over the past 40 years, more individuals are living with disabilities or chronic conditions. This is especially true for people with Intellectual and Developmental Disabilities (I/DD), whose lifespans now often mirror those of the general population due to medical advancements. As a result, the number of adults with I/DD aged 60 and older is projected to double between 2000 and 2030. Many of these individuals outlive their family caregivers and require sustained support through Medicaid and other programs.

The need for long-term care also rises with age- An estimated 70% of individuals over 65 will require some form of Long-Term Services and Supports (LTSS), with even higher rates among older age groups. The trend over time has been for older adults and people with disabilities to access more services, not fewer, which increases costs. This is because most chronic conditions, even when managed well, worsen as people age. We do not believe that people are struggling to access services and becoming sicker as a result.

There is an overreliance on Medicaid- Those needing LTSS are more likely to have incomes below the federal poverty level, making Medicaid the only viable option to cover their care.

This confluence of factors— increasing lifespans, aging populations and higher poverty rates among those requiring LTSS—places growing financial pressure on Medicaid programs nationwide. Older adults and individuals with disabilities have always been a complex population to serve, as they typically require care for multiple comorbidities and chronic conditions. For example, 86% of Colorado's Medicaid LTSS population has at least one chronic condition, compared to only 28% of non-LTSS Medicaid members. Furthermore, 37% of LTSS enrollees have five or more chronic conditions, underscoring the severity of their health

challenges. This complexity leads to greater utilization of services across Medicaid, including LTSS, acute care, behavioral health, and pharmacy benefits. In Colorado, the average number of services accessed per LTSS member increased from 128.49 in FY 2020-21 to 137.37 in FY 2023-24, reflecting the growing demand for multifaceted care.

Medicaid covers a disproportionate share of these increasing costs- LTSS are predominantly financed through public programs. While Medicare provides limited LTSS coverage, Medicaid bears the vast majority of these costs. Nationally, Medicaid accounted for 61% ($415 billion) of LTSS expenditures in 2022, with private out-of-pocket payments contributing 21%, and other sources, such as the Department of Veterans Affairs or long-term care insurance, covering the remaining 22%. Given Medicaid's role as the primary payer for LTSS, states across the country, including Colorado, are experiencing rising costs to sustain these services.

In conclusion, people with disabilities are living longer; many are doing so with complex and chronic medical conditions that require extensive support. Colorado has responded by expanding access to Home and Community-Based Services (HCBS) and leveraging advances in LTSS to meet these needs. However, these trends have led to enrollment and utilization growth, reinforcing the long-term trajectory of rising per capita costs in Colorado's Medicaid program. These national and state-level dynamics underscore the challenges of managing costs while ensuring high-quality care for a growing and aging population. Details on HCPF's strategies to ensure sustainable growth are detailed in question 3.

10. **[Sen. Amabile/Sen. Bridges] Why are costs for people with disabilities and the elderly increasing? Please discuss each population independently. How much of the FY 2025-26 forecast for these populations is attributable to provider rate increases, enrollment, changes in utilization per member, or other factors.**

RESPONSE

Creating a high-quality, sustainable system that appropriately supports the needs of older adults and people with disabilities is central to HCPF's policy and fiscal strategies. An effective oversight process that ensures members have timely access to the services they qualify for is essential to achieving this vision.

Nationally, Medicaid recipients who access long-term services and supports (LTSS) comprise only 6% of the total Medicaid population but account for 34% of Medicaid spending. Colorado's experience is similar to the national experience, with our LTSS population accounting for 4.7% of our total Medicaid population yet generating 42% of our total Medicaid spending. The variance is considerable, though, across states. For instance, some of the states with the highest spending on LTSS as compared to overall spending in their Medicaid program are North Dakota, 54.9%, Wyoming, 54%, and Kansas, 51.2%. When comparing Colorado to other states on Medicaid LTSS expenditures, Colorado sits relatively in the middle at #21.

In Colorado, costs to support older adults and individuals with disabilities who receive LTSS continue to grow due to several interconnected factors, including rate increases, increases in utilization, and population growth resulting in enrollment growth.

The most significant cost driver for LTSS programs is rate increases. Just under fifty percent (50%) of the expenditure increases over the past five years were due to increases necessary to raise the base wage of direct care staff to keep pace with minimum wage, inflation and to allow Medicaid providers to remain competitive with other low-wage industries. To offset the general fund impact, the state was able to leverage the American Rescue Plan Act (ARPA) Home and Community-Based Services (HCBS) funding for a significant portion of the initial costs for these rate increases, with the commitment from the legislature to provide the ongoing appropriation. HCPF continues to identify ways to leverage the ARPA funds to support providers while they are still available, including a proposal to utilize all remaining funds for direct provider payments in early 2025.

After rate increases, the second largest driver of cost is increases in utilization. Nearly 40% of the expenditure increases since FY 2021-22 were due to utilization increases. Approximately 70% of those increases were specifically in Long-Term Home Health (LTHH) and In-Home Support Services (IHSS).

- Over the last four years, utilization per member has increased 33% for these two services. The sharp increases in LTHH are, in part, attributed to the Prior Authorization Request (PAR), or utilization management, being paused. HCPF anticipates that LTHH will continue to grow until the spring of 2025, when utilization management practices are implemented (see more on this below) and that IHSS will continue to grow at a slower rate in the forecast, especially after a complementary policy with a higher federal match is implemented.

- HCPF is projecting an increase of $72.6 million from FY 2023-24 to FY 2025-26 for LTHH, including rate increases approved as a part of the FY 2024-25 Long Bill. Of the $72.6 million, approximately $13.6 million (19%) is associated with rate increases, while the remainder is associated with increases in utilization. Of the total LTHH increases in the forecast, $8.6 million is projected for older adults, $50.8 million is projected for individuals with disabilities, and the remaining $13.2 million is projected for other eligibility categories including children and adults who do not fall under HCPF's disability eligibility categories.

Preference and access have shifted more care delivery to home and community-based settings, reducing reliance on nursing facilities. IHSS is one of the service types that has allowed members to receive care at home and in their community. While IHSS utilization has grown across various waivers, there has been a corresponding decrease in nursing facility use. To support this transition, HCPF, in collaboration with the JBC, has taken steps to expand access to these service options while maximizing federal funding opportunities. During the 2023 legislative session, SB 23-289, the "Community First Choice Medicaid Benefit," was enacted. This legislation allows HCPF to secure an additional 6% federal match rate for services such as Personal Care, Homemaker, and Health Maintenance, which make up the IHSS

delivery model, by changing the authority by which we are granted federal approval. This shift is projected to generate General Fund savings starting in FY 2025-26, providing a return on the state's significant investments in these essential services.

HCPF has several utilization management strategies to ensure appropriate and effective care for the LTSS population:

- LTHH prior authorization requests (PARs) will be re-implemented effective spring 2025, which will help address one of the significant trend challenges.

- The new Skilled Single Nursing Assessor, approved last session as part of R-10, "Third Party Assessments for Nursing Services," is scheduled to be launched in July 2025. This nurse assessor will conduct a clinical assessment that is aimed at mitigating the risk of duplicative authorization across all three skilled care modalities while also streamlining and improving the process for members.

The majority of the remaining increases for LTSS come from the enrollment growth on the waivers. Enrollment in long-term care services is limited to those who meet the necessary eligibility criteria, which include financial thresholds and assessments of functional limitations, ensuring that these resources are allocated to those with the highest levels of need. For the Developmental Disability (DD) Waiver, enrollment is limited as there is a waitlist, but this limitation is not in place for any other waiver programs.

Colorado's population of adults aged 65 and older is growing rapidly, resulting in expected enrollment increases. Older adults receiving LTSS must also have a qualifying disability and meet level of care requirements to be eligible. Enrollment in HCBS waiver programs is expected to grow from 50,034 in FY 2023-24 to 54,416 in FY 2025-26, representing an 8.8% increase. While this may seem small, the increase in enrollment is skewed towards more expensive waiver options, often serving members with the most complex needs, like the Developmental Disability (DD) waiver, Children's Habilitation Residential Program (CHRP), and the Brain Injury (BI) waiver. In particular, the DD waiver has grown in the past couple of years due to funding spots from the DD waitlist:

- The JBC committed funding to reduce the DD waitlist by 667 members during the 2021 legislative session and 129 members during the 2024 legislative session. Due to the availability of residential care options, the DD waiver is one of HCPF's most expensive waivers.

- In FY 2023-24, the DD waiver cost an average of $98,000 per member, not including state plan services. Many members who moved to this waiver previously received care under the Elderly Blind and Disabled (EBD) or Supported Living Services (SLS) waiver. Due to service limitations and availability, the EBD waiver costs an average of $36,000 per member in FY 2023-24, while the SLS waiver costs an average of $23,000 per member.

HCPF has also seen increases in acute care service utilization and behavioral health utilization for all populations, including older adults and individuals with disabilities. Between increases in rates, enrollment, and utilization, there has been an increase of $66.7 million for older adults and $279.6 million for people with disabilities in acute care services. Since FY 2020-21, HCPF has seen the largest increases in costs for nonemergent medical transportation, emergency transportation, and durable medical equipment services in acute care for these populations.

HCPF also had an increase of $55.0 million in behavioral health care expenditure for older adults and people with disabilities from FY 2020-21 to FY 2023-24, of which $5.9 million was for older adults and $49.1 million was for people with disabilities. HCPF forecasts that between FY 2023-24 and FY 2025-26, capitation expenditures will increase by approximately $47.5 million.

It is anticipated that the costs to support older adults and individuals with disabilities will continue to rise due to the factors outlined above. Colorado's aging population is driving enrollment growth, which is expected to persist. Additionally, due to improvements in health care and access to LTSS, individuals with disabilities are living well into older ages, increasing demand for services. As people live longer, they often experience complex health conditions that require extensive support, which can drive up both the per-member and total costs of care. To ensure that Medicaid providers can compete with other industries in recruiting and retaining direct care workers, rate increases will also remain necessary, particularly as state and local minimum wages continue to climb. Utilization of specific services has also grown significantly in recent years, and HCPF is closely monitoring these trends to ensure that services are both appropriate and necessary.

11. **[Rep. Bird] what is driving the caseload growth for Adult Comprehensive waiver services?**

RESPONSE

The caseload growth for the Adult Comprehensive or Developmental Disabilities waiver is driven by the JBC's authorization last session to add 129 members to the waiver in FY 2024-25, plus priority enrollments authorized through reserve capacity each year. In FY 2023-24, 307 reserve capacity enrollments were authorized. These reserve capacity enrollments are considered emergency or priority enrollments and can be requested when the health, safety, and welfare of an individual or others are in danger due to homelessness, an abusive or neglectful situation, danger to others, danger to self, or the loss or incapacitation of a primary caregiver. The reserve capacity also includes enrollments for children from the Children's Habilitation Residential Program and Children's Extensive Supports waivers when they age out of these programs and need adult services.

12. **[Rep. Taggart] Please provide details on the projected caseload declines for the Children's Extensive Support waiver and the Children's Habilitation Residential Program waiver. What are the reasons for the projected caseload declines in FY 2026-27?**

RESPONSE

The FY 2026-27 projections in the R-5 request are informational only and have no impact on HCPF's official request for funding in FY 2025-26 for Medicaid services. The projected decline in enrollment in FY 2026-27 for those two waivers was not intentional. HCPF will revise the informational-only figures for FY 2026-27 as part of the February forecast and anticipates that the projected enrollment growth rate will be more consistent with the projected growth rates for the two waivers in FY 2025-26 of 11.2% for CES and 11.5% for CHRP.

13. **[Sen. Amabile/Sen. Kirkmeyer] The Department is projecting that in FY 2025-26 enrollment will increase by 4,009 for the elderly and 6,221 for people with disabilities. At the same time, the Department is projecting expenditures will increase $12.5 million for the elderly and $304.6 million for people with disabilities. How is it possible for those increases in population to drive such large increases in expenditures?**

RESPONSE

To clarify, HCPF is projecting that the costs for older adults who receive LTSS and have a disability will increase by $121 million (not $12.5 million) from FY 2024-25 to FY2025-26 and $304.6 million for people with disabilities during the same timeframe. It is important to note that at the age of 65, Medicare becomes the primary insurer, covering acute care costs such as pharmacy, hospital and primary care. However, for people with disabilities, the primary option (outside of private pay, long-term care insurance, or other less common alternatives) for long- term services and supports is Medicaid. Thus, individuals 65 and older, and some younger who qualify, are dually covered.

The significant disparity between enrollment growth and expenditure increases for older adults and people with disabilities in Medicaid reflects several interconnected factors tied to the higher acuity and complexity of these populations, as discussed in other responses. While the projected enrollment growth of 4,009 older adults and 6,221 individuals with disabilities from FY 2023-24 to FY 2025-26 represents a modest caseload increase, these populations disproportionately drive costs due to their more intensive care needs and the services they utilize.

Home and Community-Based Services (HCBS) waivers alone are projected to grow from $1.226 billion in FY 2023-24 to $1.646 billion in FY 2025-26, with $99.6 million (23.7%) of this growth directly attributable to rate increases approved in the FY 2024-25 budget; driven primarily by rate adjustments to support recruitment and retention of the workforce, a critical factor given the increasing demand for services as more individuals require in-home and community-based care.

Utilization growth also plays a significant role in expenditure increases, particularly within Home- and Community-Based Services (HCBS). HCPF forecasts $182.1 million (43.4%) of the HCBS waiver cost growth to stem from rising service utilization, especially in programs like In-Home Support Services (IHSS) and through the inclusion of Community First Choice (CFC) in the State Plan. However, CFC costs to the state will be offset by the enhanced federal match

associated with this program. Enrollment growth within HCBS waivers, projected to increase by 2,882 members from FY 2023-24 to FY 2025-26, adds another $137.8 million (32.8%) in costs. Notably, the increases in utilization are primarily concentrated among members with disabilities, while rate increases and enrollment growth are split between both older adults and individuals with disabilities.

Beyond HCBS, other LTSS programs such as the Program for All-Inclusive Care for the Elderly (PACE) contribute to expenditure growth. PACE costs are expected to rise by $73.7 million from FY 2023-24 to FY 2025-26, driven largely by rate increases tied to investments in both HCBS and nursing facility services. PACE rates are calculated based on fee-for-service LTSS costs, including those affected by HB 23-1228, which established new nursing facility reimbursement rates.

In summary, the higher costs associated with serving older adults and individuals with disabilities in Medicaid stem from a combination of factors: higher acuity and service needs, investments in workforce and provider rates, and increased service utilization in both LTSS and acute care. While enrollment growth appears modest, these populations disproportionately impact expenditures due to the intensity of care required and the long-term nature of their needs. The investments and policy changes made by HCPF and the legislature, such as those supporting HCBS and PACE programs, reflect a broader shift toward enhancing care delivery and meeting the needs of these vulnerable populations, albeit at a significant cost. These trends underscore the broader dynamics driving Medicaid cost growth in Colorado and nationwide.

14. **[Rep. Taggart] Why does the Department need to contract for the screenings to ensure nursing residents receive appropriate care and for the quadrennial nursing facility appraisals requested in R13? Would it be better to perform these functions in house?**

RESPONSE

In response to the Screenings:

Pre-Admission Screening and Resident Reviews (PASRR) are federally required for all individuals seeking placement in a nursing facility. If an individual is determined to have an intellectual or developmental disability or mental illness and the placement is determined appropriate, a secondary screen is required to ensure that needed specialized services are provided.

HCPF has chosen to contract for this work. To complete the PASRR process in-house would require HCPF to acquire a data and software system capable of processing all of the PASRR data and hire both Qualified Mental Health Professionals (QMHPs) and Qualified Intellectual Disability Professionals (QIDPs) to complete the PASRR screenings and evaluations. Because of these federal requirements, having an experienced vendor perform these screenings is far more cost-effective as it allows specialized organizations to disperse some of these fixed costs across multiple state contracts. Finally, an enhanced 75% federal match is provided for PASRR activities, further decreasing costs to the state.

In response to the Appraisals:

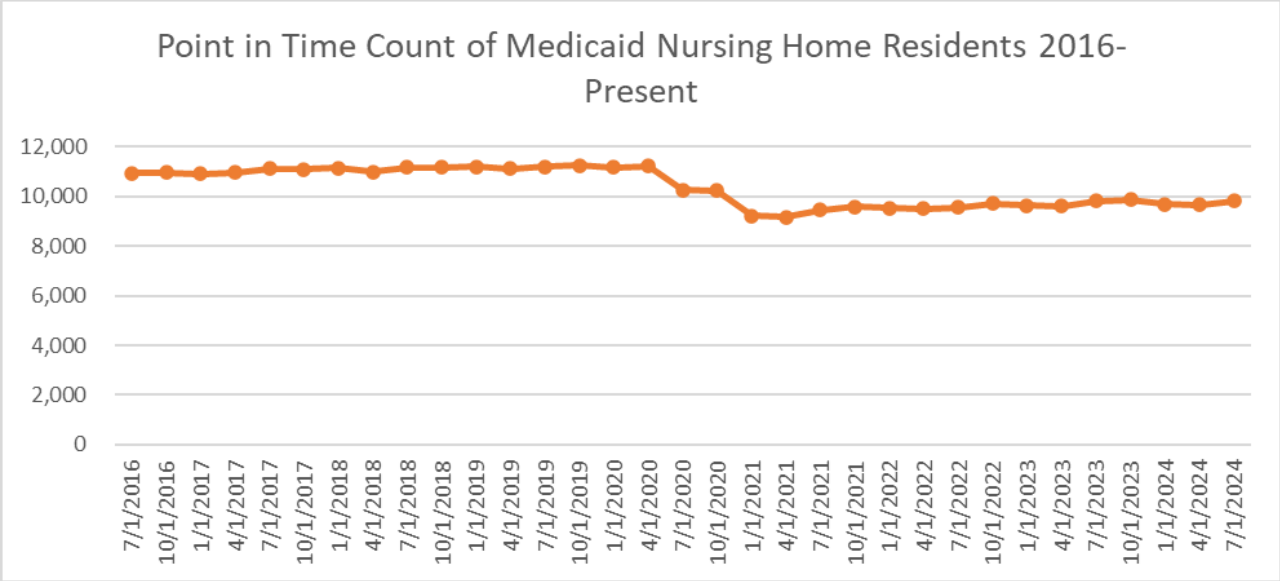
The nature of this work is real estate appraisals. HCPF hires a contractor to conduct an analysis on the "fair rental allowance" of all Medicaid nursing homes and non-state operated intermediate care facilities for the purpose of rate setting as required by C.R.S. 25.5-6-202. HCPF does not retain this sort of expertise in our usual course of business. In addition, the task is only conducted once every four years, which would make hiring such professionals as HCPF employees inefficient and more costly.

KEEPING PEOPLE IN COMMUNITY AS SUSTAINABLE GROWTH STRATEGY

15. [Sen. Amabile] How have the increases in utilization of Home- and Community-Based Services impacted nursing home expenditures? Are we saving money?

RESPONSE

Nursing home utilization has remained relatively flat for an extended period, a trend observed both before and after the COVID-19 pandemic (see chart below). This stability reflects a growing preference among Medicaid members to receive care at home and in the community rather than in institutional nursing facilities, despite these populations often having similar demographics and care needs. In FY 2023-24 HCPF served 83.4% of the long-term services and supports population in the community. With Colorado's aging population expanding at a dramatic rate, the demand for Home and Community-Based Services (HCBS) services has outpaced the modest declines in nursing home utilization, further driving growth within HCBS programs. Growth in HCBS aligns with individual preferences to remain at home, and serving individuals in the community has a lower cost than providing care in institutional settings.



This shift aligns with HCPF's broader person-centered care initiatives and utilization management strategies. As highlighted in other responses, expanding member-directed programs, like In-Home Support Services (IHSS), has facilitated the delivery of services in more flexible, community-based settings. The cost of care for individuals in HCBS waivers is typically lower than those in nursing facilities, resulting in a net per-person savings while meeting members' needs. It is important to note that though providing services and supports through HCBS has traditionally been a lower-cost approach, HCPF has observed trends that demonstrate the cost differences are shrinking. In FY 2021-22, the total cost of care for Medicaid LTSS members 65+ was 50% of those members residing in nursing facilities, and that percent had increased to 59% by FY 2023-24. Despite this, HCBS still results in significant cost savings over nursing facilities. While there are often differences based on which nursing facility people reside in and what their additional Medicaid costs may be, the FY 2023-24 average total cost of care for an adult member living in a nursing facility was $63,820. The same context around variability can be said for HCBS, where individuals utilize services that vary in cost depending on need. However, in FY 2023-24 the average total cost of care for an adult member receiving HCBS was $56,110.

Legislative actions, such as SB 23-289, which expands federal funding through Community First Choice (CFC), further support this transition by ensuring sustainable investments in HCBS services. Additionally, efforts to ensure member choice in service setting were approved through the FY 2022-23 BA-07 and FY 2023-24 BA-08 budget requests. These programs are designed to help members interested in transitioning to the community to do so, and in turn will save the state money. For example, the In-Reach programs will proactively provide members living in nursing facilities information about transition services and community-based options and offer referral to transition services when requested. These trends reflect HCPF's ongoing efforts to balance member choice, fiscal responsibility, and the efficient allocation of resources as enrollment and service utilization grow among older adults and individuals with disabilities.

16. **[Sens. Bridges and Kirkmeyer] Are the requested FTE new positions or funding for currently existing positions?**

RESPONSE

The two FTE requested in R-11 for the continuation of the Complementary Integrated Health (CIH) waiver are extensions of existing positions at HCPF that are filled and charged with administering the waiver. These positions were originally funded through SB 19-197 and SB 21-038. These two bills were annualized out of HCPF's base budget due to the statutory repeal of the waiver, including the funding for the two positions. Given the workload associated with managing Home and Community-Based Services (HCBS) waivers, HCPF is requesting to extend the funding to maintain these two FTE ongoing.

These FTEs are necessary to provide continued oversight for HCBS benefits for the CIH waiver and the rendering providers. Since 2019, the two FTEs have been working to expand provider capacity to ensure access to care, as well as assist with benefit management and stakeholder engagement. In addition to provider recruitment and assistance with the Medicaid enrollment

process, the FTEs provide technical and billing assistance to providers and direct outreach to members and their case managers to directly connect them to these providers. The FTE also monitors program utilization, quality, and cost-effectiveness of each of the services and ensures federal compliance with the CIH waiver. The FTEs are also essential to the continued successful management and oversight of this waiver. These FTE additionally support members and their case managers with technical assistance as well as helping them access the CIH waiver and services. Continuing the waiver without the existing FTE would be extremely problematic and create a situation in which HCPF would not be able to manage the program, meet CMS federal requirements, and perform the work requested by members, providers, and other key stakeholders.

17. **[Rep. Bird] How many children are in hospitals waiting to be discharged? How much is this backlog costing?**

RESPONSE

To best ensure cross-agency collaboration for children with the most significant health care needs, a process was created for hospitals to escalate directly to HCPF instances when safe and appropriate services post discharge are difficult to put in place due to the extraordinary needs of the child. In FY 2023-24, there were 76 children statewide who were escalated through this process.

The reasons hospitals need support creating discharge plans for these children are complex and multi-factored. Several common examples for why a child may need cross agency discharge support for medical needs include:

- The family home not being suitable or stable enough for a medically complex child, such as no space large enough for a hospital bed and ventilator equipment.
- The family is not able to care for the child's particular needs at home, requiring relocation to a facility with staff to provide oversight and care.
- The child's guardian is not willing or able to complete hospital required training to care for their child or does not want their family members moved from the hospital to another facility that may be a more appropriate level of care.

For children with significant mental health needs, the solution is often unique, requiring cross agency teams to develop individualized approaches that best ensure the success and safety of the child. Often, children may not receive services alongside other children or return to the family home as they have been determined to pose a risk to others or a child may have needs that require one-on-one staff. Children who are escalated for additional discharge support may also be in foster care, which requires additional coordination to ensure the foster family or reunification process are appropriately resourced prior to discharge.

While a child is medically ready to discharge, there is also a responsibility to ensure there is a safe discharge plan in place, and for children with the most complex needs that can take some time to get right. The challenges the cross-agency teams face in planning are not insignificant and not always readily solved through a policy solution. For example, a child cannot be discharged with a nurse if they have no home to go to. Most of the time, a need for

a nurse is not the primary factor for a child remaining in a hospital after they are deemed ready to discharge.

The per member cost for delayed discharge out of the hospital depends on the extended length of stay in the hospital and the reason for the hospital stay. In the aggregate, the cost associated with the 76 children who were waiting to be discharged from the hospital was approximately $5,463,161 in FY 2023-24. This type of linear analysis is incomplete, as the cost for inappropriate or inadequate placement, while not quantifiable, would likely be much higher.

INVESTING IN WORKFORCE TO KEEP PEOPLE IN COMMUNITY

18. **[Sen. Bridges] What are the typical overhead expenses to service costs for agencies providing home health and providing assistance with activities of daily living? Why are the overhead costs so high?**

RESPONSE

HCPF does not collect information regarding the overhead of provider agencies. The decisions that influence an agency's overhead are largely the result of the owners and/or administrative entities. However, we have conducted significant research on the elements that influence long-term care providers within Medicaid.

Provider overhead costs are dependent on several factors, including the service(s) they provide, location, and the benefit or compensation package they offer their employees. For example, many services are rendered in a provider-owned setting but instead are rendered in a Medicaid member's home. In these scenarios, a provider would not have the overhead cost of a large facility or clinic but may still have an office space where costs could vary. HCPF is aware that the following are typical overhead costs incurred by agencies: office space rent, utilities, insurance (liability, workers' compensation), staff salaries (including non-direct care staff like administrative personnel), marketing and advertising, licensing fees, vehicle maintenance or transportation costs for staff traveling to homes, supplies, and administrative costs for employee recruitment, training, employee benefits, and taxes. Additionally, some providers incur costs for technology and software, such as electronic health records and scheduling platforms. High turnover rates in the field also contribute to increased costs, as recruitment and onboarding of new staff are resource intensive.

Industry standards and financial benchmarks for health care show the allocation of revenue from Medicaid long-term care services typically breaks down as follows:

- Wages: 65%
- Overhead: 25-30%
- Net Margin: 5%

HCPF does have extensive data on the average wages for individuals rendering Home and Community-Based Services. For example, the average hourly wage for personal care is $18.44/hr, while the agency is reimbursed $28.08/hr for this service. Without factoring in any additional benefits, we can show that 66% of the reimbursement rate is paid to the worker.

HCPF has publicly expressed interest in working with key provider partners on furthering our data collection and intends on using existing pathways (our Direct Care Workforce Collaborative, the Direct Care Workforce Stabilization Board, etc.) to research this topic further and better understand the various factors that contribute to overhead.

19. **[Rep. Amabile] How much would a rate increase change the nursing shortage?**

RESPONSE

The nursing shortage is the byproduct of many intersecting issues; ensuring this workforce has a competitive wage is just one component. It is unclear if a rate increase would significantly impact the number of nurses in Colorado. HCPF reimburses organizations that compensate the nurses they employ or contract with. While HCPF does not track nurses' salaries or compensation for nursing services, this information will be collected in the future due to a federal rule that was recently finalized requiring HCPF to gather information by July 2028.

The nursing shortage is a nationwide issue. Many nurses are nearing retirement, and there is insufficient training capacity due to limited faculty and clinical spots. Further, there is also growing demand due to the expanding aging population and individuals with increasingly complex health care needs, which creates additional pressure on the workforce. While a salary increase for nurses could help reduce burnout and retain more nurses in the profession, it is unlikely to solve the problem. Research shows that addressing working conditions, enhancing training opportunities, and offering comprehensive employer benefits are also critical to building a sustainable workforce.

20. **[Sen. Bridges] Was the wage increase approved by the General Assembly last year passed through to employee wages? How do we know?**

RESPONSE

Since February 2022, HCPF has required Home and Community-Based Services (HCBS) providers to submit an annual wage attestation form to confirm that Direct Care Workers (DCWs) received the required base wage increase. This requirement has continued through 2023 and 2024 and will be ongoing as outlined in 10 C.C.R. 2505-10, Section 8.511. This rule requires that each HCBS provider report on the wage paid to each worker they employ. If a provider fails to comply in the allotted time frame (60 days), their claim payments will be held until compliance is demonstrated. HCPF also conducts many compliance reviews and audits of providers to verify that DCWs are being paid the required wage and in alignment with the information reported on the attestation forms. While uncommon, HCPF works with

providers to correct DCW wages when issues are found. Additionally, HCPF collaborates with the Colorado Department of Labor and Employment (CLDE) to disseminate information about the required base wage and to refer wage complaints for further investigation.

BEHAVIORAL HEALTH

21. **[Sen. Amabile] We would expect high acuity patients to have been enrolled before the pandemic, so high acuity patients would not explain increases in forecasted costs alone. Please provide data or information to describe any increases in utilization or newly covered services specific to behavioral health that would help explain forecasted expenditures compared to pre-pandemic expenditures.**

RESPONSE

The increases in expenditures can be attributed to four major areas: network improvement (more providers available), service expansion (more services available), greater access (higher utilization per person), and increased reimbursement (higher costs per service).

Network improvement: Prior to the pandemic, in FY 2018-19, the newly formed RAEs were contracted with 6,391 providers across their combined networks. Post pandemic in FY 2023-24, that number was 12,478 providers, an increase of 95%.

Service expansion: Since 2017, the legislature has expanded behavioral health services and benefits available including the below. All dollars are the estimated impact within FY 2024-25:

- From HB 18-1136, SUD Residential and Inpatient services- $110 million.
- From SB 17-207 and HB 22-1214 Mobile Crisis Response - $1.25 million.
- From SB 21-1085, Secure Transport services - $1 million.
- From SB 22-131, Supportive Housing - $867,000.
- From HB 22-1203, Mental Health Transitional Living - $3.79 million.
- From SB 22-156, Removal of Prior Authorization for Psychotherapy Services - $38.8 million.

In total, these bills have increased the cost of the behavioral health benefit by approximately $156 million total funds.

Greater access: Since the pandemic, the number of unique members utilizing services has grown tremendously. In June 2019, the number of utilizers per thousand members was approximately 61. By the end of the PHE unwind in June 2024, the number of utilizers per thousand members was approximately 86, a 41% increase. This is true even for services that are not considered high acuity. As an example, the number of unique members receiving at least one 60-minute session of psychotherapy went from approximately 67,000 in FY 2018-19 to approximately 111,000 in FY 2023-24. This represents an increase of over 64%.

Increased reimbursement: The costs to provide services have increased significantly since FY 2018-19 when Colorado last saw this level of Medicaid enrollment. Some of these increases were legislatively mandated and some were cost inflation driven during the COVID and post-COVID periods. Some of this cost inflation relates directly to the general acuity level of the population.

- 2019 - The Long Bill required RAEs to raise rates for BH providers by an average of 2% across the board.
- 2020-2023 - RAEs engaged in updating fee schedules for the Independent Provider Network (IPN). Some fee schedules increased by over 30% over four years. The total dollars RAEs paid out to the IPN increased from $167 million in FY 2020-21 to $357 million in FY 2023-24, an increase of more than 100%. When considering the lower membership in FY 2023-24, this is a per member increase of 125%.

- Rate increases pre-pandemic were generally at or below 4% per year. Due to inflation and wage increases, trends have been much higher. Since 2020, the combined utilization and cost trends within the capitation rates were at an average of 5.8% per year for a total of a 25.3% change as of the FY 2023-24 rates. This is after program changes, acuity, and fee schedule increases. These trends break down to approximately 5% trend in utilization and .8% trend in costs per unit of service per year.

- From FY 2022-23 to FY 2023-24 the per member per month capitation rates increased 9.56%. From FY 2023-24 to FY 2024-25, the capitation rates increased by 21.67%. Aside from the new services and the trend described above, a large component of this was an adjustment for population acuity. For the FY 2023-24 rates, the adjustment was 4.26% to account for the process of the PHE unwind. For the FY 2024-25 rates, this acuity adjustment jumped precipitously. The adjustment varied by RAE from 15.15% to 30.08%. This is a direct result of the higher utilization being spread across a much lower number of participants.

22. [Sen. Bridges] Please describe the dollar amounts and percentage of the behavioral health forecast driven by newly eligible services, the number of people being seen, and payment per service.

RESPONSE

The factors listed below are the primary drivers of the increase in behavioral health services from FY 2019-20 through FY 2023-24, which then informed the rate setting for behavioral health in FY 2024-25 and the forecasted trends into FY 2025-26.

There have been a number of newly authorized services added to the behavioral health rates as a result of legislation and approved budget requests since FY 2017-18. The dollars and percentages are relative to the estimated FY 2024-25 capitated rates. These services include:

- HB 18-1136 SUD inpatient and residential services - ~$110 million or 10.2%.
- SB 17-207 and HB 22-1214 Mobile Crisis and Response - $1.25 million or 0.11%.

- HB 21-1085 Secure Transport - $1 million or 0.093%.
- SB 22-131 Supportive Housing - $867,000 or 0.08%.
- SB 22-156 Removal of Prior Authorization for Psychotherapy services - $38.8 million or 3.6%.
- HB 22-1303 Mental Health Transitional Living Beds - $3.79 million or 0.35%.

In total, these bills have increased the cost of the behavioral health benefit by approximately $156 million total funds. In addition to newly authorized services, there have been significant increases in both cost and utilization trends for behavioral health rates. These increases include:

- The amount of dollars paid to the Independent Provider Network (IPN) in 2024 compared to 2021 – increase of $190 million or 113%.

- Inflation in costs of services and utilization increases since 2021 without accounting for new services – 25.3% total increase from FY 2019-20 to FY 2023-24. This alone accounts for an increase of approximately $158 million.

The number of unique members utilizing services has also grown significantly. During the pandemic, despite the large increase in membership, the rate or percentage of unique members using services increased. Additionally, once the number of members decreased due to the end of the PHE, the number of unique members using services continued to increase relative to the size of the population.

- The rate of utilization of unique members within the capitated benefit in FY 2018-19 was 14.1% while the rate of utilization of unique members in FY 2022-23, during the height of enrollment, was 15.4%. This represents an increase of 9.3%. This is unusually high given that during increased enrollment, especially at the level of the PHE, HCPF would expect to see a drop in the rate or percentage of utilization. This increase in utilization accompanied a 34% increase in membership.
- The number of unique utilizers per thousand members in June 2019 was approximately 61. The number of unique utilizers per thousand members in June 2024, after the PHE unwind end, was approximately 86. This represents a 41% growth.

23. [Sen. Amabile] Why did the Department underspend the appropriation for behavioral health in FY 2023-24? The JBC hears consistent concerns about the demand for services. Is there a barrier preventing money from getting to the services?

RESPONSE

HCPF underspent its appropriation by $98,914,551. This was not driven by any barrier preventing payment for medically necessary services, but rather the following components: differences in caseload, PHE rate adjustments, population adjustments, and the timing of the Behavioral Health Incentive Program payments.

One component of HCPF's behavioral health program includes the Behavioral Health Incentive Program (BHIP). The BHIP is a funding initiative designed to reward improved health outcomes and cost containment within the Medicaid system. It is part of the larger Accountable Care Collaborative (ACC) program and rewards Regional Accountable Entities (RAEs) for meeting specific performance targets tied to behavioral health services. Payments are calculated based on performance indicators that assess the RAEs' success in delivering key services such as well visits, oral evaluations, and lead screenings. These measures are evaluated over rolling 12-month periods, and RAEs receive financial incentives if they meet the established targets.

For FY 2023-24, HCPF determined that BHIP payments for FY 2022-23 dates of service totaled $22,738,030, which amounted to 39.7% of the total FY 2023-24 appropriation for the BHIP of $57,328,384. However, because of the time required for HCPF to calculate and issue payments, these payments were not processed by the end of FY 2023-24. That contributed to a reversion of $57.3 million in FY 2023-24. We adjusted the forecasted expenditure for the BHIP payments in the forecast for FY 2025-26.

Differences in caseload also contributed to underspending in the behavioral health appropriation. HCPF estimated that variations in caseload resulted in $11.5 million of the reversion.

During FY 2023-24, actuaries reviewed the behavioral health capitation rates to ensure they remained actuarially sound following the PHE unwind. This review considered the higher utilization and needs of members retaining coverage through the PHE unwind, as compared to those disenrolling. The evaluation included factors such as utilization trends, cost trends, and the acuity of the population. Through this analysis, actuaries identified a variation exceeding 1.5% from the agreed-upon rates, requiring HCPF to make a rate adjustment per 42 CFR 438.7, retroactive to July 1, 2023. The projected fiscal impact of this rate change that was included in HCPF's FY 2023-24 appropriation was $81,931,539. However, final calculations in late FY 2023-24 showed the final payments were $66,984,548, resulting in $14.9 million of the reversion.

Finally, population adjustments in FY 2023-24 contributed to $13.4 million in underspending in the behavioral health appropriation. HCPF applies adjustments to the capitation forecast based on historical ratios of Medicaid enrollment compared to the number of individuals on Medicaid for whom HCPF pays behavioral health capitations. Behavioral health capitations are not paid for Medicaid individuals who are out-of-state, incarcerated, or enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Final FY 2023-24 data showed that HCPF paid fewer capitations than expected based on the FY 2023-24 caseload.

BHIC AND THE BHA

24. [Sen. Kirkmeyer] How is the Department coordinate with the BHA on an ongoing basis? How do the two agencies coordinate to ensure there is not duplication of services, or gaps in services, between the two agencies?

RESPONSE

BHA is charged with leading and developing the state's vision and strategy for behavioral health in Colorado. Every state agency that administers a behavioral health program is required to collaborate with BHA to achieve the goals and objectives established by BHA. In addition to formal written agreements, HCPF participates in the interagency council, chaired by BHA's Commissioner, made up of 12 executive directors of state agencies that administer behavioral health programs in which BHA coordinates multiple initiatives across state agencies. To promote efficient and unduplicated services, BHA and HCPF also engage in daily communication, collaboration, and coordination from individual contributors to senior leadership. BHA and HCPF are aligned in such a way that even our foundation pillars align.

Pillars of BHA	Pillars of HCPF
Access	Care Access
Affordability	Affordability Leadership
Workforce and Support	Employee Satisfaction
Accountability	Operational Excellence and Customer Service
Whole Person Care	Member Health
Lived Expertise and Local Guidance	Health First Colorado Value

As the largest payer of behavioral health services in the state, HCPF is partnering closely with BHA, along with local communities, safety net providers, advocates, members and families, to inform the design and implementation of policies to a coordinated, cohesive, and effective behavioral health system in Colorado. HCPF and BHA coordinate through integrated planning, data sharing, joint stakeholder engagement, and aligned policies to ensure efficient service delivery, address gaps, and prevent duplication in behavioral health care. The shared BHA and HCPF pillar of 'Access To Care' is highlighted through the development of the safety net system. HCPF and BHA do not just share the intention of collaboration but have multiple policies and programs that demonstrate that alignment.

Safety Net Reform: HCPF and BHA have worked closely to ensure that reforms and the implementation of Colorado's Safety Net system are cohesive. BHA defines and regulates safety net services and providers, then HCPF relies on those definitions and licenses to enroll BH providers in Medicaid. BHA and HCPF worked closely through the regulatory review process to ensure Medicaid regulations and infrastructure were considered throughout the new rule structure and the BH service definitions did not include any services that could not be covered by Medicaid. This close collaboration then informed HCPF's reform efforts related to creating pathways to enroll, identify, and reimburse safety net providers, and has led to a significant increase in licensed safety net providers enrolled in Medicaid. Through co-

facilitated stakeholder engagement, coordinated responses to providers, and jointly developed FAQs, the new Safety Net system went live in July 2024.

As of December 12, 2024, BHA has issued 19 Comprehensive Provider approvals, 18 are enrolled with HCPF across multiple locations, and one is in progress. BHA has issued 160 Essential Provider approvals and HPCF has processed 141 enrollments. Open communication and collaboration continue with weekly updates regarding BHA licenses and approvals and new HCPF enrollments shared with the Regional Accountable Entities (RAEs).

SUD Benefit: In response to expanded and discrete regulatory definitions in BHA rules, HCPF expanded Medicaid provider enrollment options to allow for the full continuum of SUD services based on the levels of care outlined in American Society of Addiction Medicine (ASAM) criteria, which also aligned with HCPF's SUD residential waiver. This SUD continuum now includes multiple levels of outpatient, high intensity outpatient, residential and inpatient enrollment categories. BHA sends HCPF a monthly report of all licensed SUD providers at every level which allows HCPF to monitor member access to SUD providers statewide. 100% of BHA-licensed Opioid Treatment Programs (OTPs) are enrolled as Medicaid providers, 53% of licensed Residential SUD providers are enrolled as Medicaid providers, and 50% of Essential Safety Net providers are enrolled as SUD providers. In preparation for the transition from ASAM 3rd Edition to ASAM 4th Edition taking effect July 1, 2026, HCPF and BHA are co-facilitating a withdrawal management-focused workgroup to gather insight from providers and collaboratively prepare for this transition.

Provider Supports: HCPF supported BHA in developing and delivering Training and Technical Assistance (TTA) modules aimed at Safety Net and independent providers as part of the BH transformations. HCPF prioritized funding through ARPA to contract with a vendor ensuring that the trainings were developed in alignment with adult learning styles and help providers meet BHA training requirements. These training modules remain available across a provider-focused Learning Management System and a Safety Net Provider website managed by BHA and HCPF, respectively. Topics include administrative functions like contracting and enrollment, licensing standards for BHA and CDPHE, evidence-based practices in program design, and financing skills like how to bill Medicaid and BHA or how to complete a cost report.

Aligning Regional Accountable Entities and Behavioral Health Administrative Service Organizations: HCPF and BHA have worked closely to thoughtfully align program design for the RAEs and BHASOs. This includes:

- **Create an aligned regional map for RAEs and BHASOs.** HCPF heard from stakeholders about the importance of aligning the RAE and BHASO regions to create simplicity and reduce confusion for those that may interact with both entities, such as members and providers. HCPF and BHA jointly hosted stakeholder meetings and reviewed statewide population data to determine the optimal region map and other considerations as both ACC Phase III and the BHASOs go live on July 1, 2025.
- **Development of joint care coordination expectations**. We heard from stakeholders about the importance of aligning care coordination standards between the RAEs and

BHASOs. Since early 2023, HCPF and BHA have worked closely to develop a tiered approach to care coordination for Medicaid members served by RAEs and Coloradans served by BHASOs. Aligning these service definitions is intended to ensure Coloradans moving from Medicaid coverage continue to receive the navigation and coordination support they need.

- **Alignment of the contracts between RAEs and BHASOs.** While RAEs serve Medicaid members, there are many members who may churn off of Medicaid and would therefore be served by BHASOs. Additionally, there are many requirements around the services that Medicaid can or cannot provide. There may be instances where BHASOs cover additional services for members. HCPF has worked closely with BHA to crosswalk key contract requirements and ongoing operations between the RAEs and BHASOs. Both agencies have looked at the general role of RAEs versus BHASOs, the administrative burden for other agencies that may need to work with both entities, care coordination expectations, requirements for community engagement, and quality and data sharing. Additionally, HCPF and BHA plan to work with both RAEs and BHASOs to ensure that network providers are trained on the role of each entity.

Children and Youth: HCPF has been actively collaborating with BHA in the development of the Medicaid System of Care around the Settlement Agreement Implementation Plan which consists of the Identification Tool, the Standardized Assessment including the Child & Adolescent Needs and Strengths (CANS) tool, and Intensive Care Coordination with High Fidelity Wraparound (HFW). The Medicaid System of Care will leverage the existing Colorado Crisis Services Mobile Response managed by BHA. In addition, the internal state group creating a proposed system of care framework consists of leaders from both HCPF and BHA. This group meets no less than weekly to ensure alignment in vision and execution for the System of Care across state agencies.

Peer and Recovery Services: HCPF continues to actively collaborate with BHA on the implementation of HB 21-1021 which directed BHA to establish rule and licensing for Recovery Support Services Organizations (RSSOs) and authorized HCPF to reimburse RSSOs for permissible claims for peer support services. HCPF and BHA staff meet at least once per month to collaborate on this work, discuss stakeholder and provider questions and concerns, and strategize on responses. As a result of this ongoing collaboration, BHA and HCPF staff have supported a smooth transition for new RSSOs to go through BHA licensing, Medicaid enrollment, and RAE contracting and billing. There are currently 8 RSSOs licensed through BHA and an additional 10 open applications. HCPF has published web-based policy guidance and FAQs for providers.

Colorado Crisis System: HCPF and BHA continue to partner on improving the Statewide Crisis Continuum. BHA and HCPF worked together to standardize Mobile Crisis Response (MCR) services in alignment with federal standards to assure appropriate reimbursement for Medicaid members and access 85% federal medical assistance percentage (FMAP) for those members. Stakeholder engagement for MCR was conducted in tandem, both in person and virtually. HCPF and BHA co-published clarifying policy memos and co-authored the MCR

Service Definition[4], demonstrating a closed loop for providers by indicating that all MCR providers must contract with the BHA ASO and the HCPF RAE, which is key to maximizing federal funding where possible. HCPF also contributed to the development of BHA's Crisis Professional Curriculum which aims to narrow the scope of training of crisis professionals to those who have completed the curriculum, thus expanding the workforce to include individuals with lived experience and various disciplines. BHA, HCPF, and CDPHE co-host monthly Crisis office hours for providers and RAEs, and regularly hold collaboration meetings, to assure alignment between regulations, reimbursement strategies, and broader crisis system goals. The 988 implementation plan[5] is an example of this alignment effort, where HCPF was tasked "with the goal of having Medicaid revenue support the crisis center (both crisis lines 988 and 844)" and has done so while supporting BHA and the 988 Enterprise through vendor transition.

CCBHC Grant: HB 24-1384 legislated that HCPF and BHA coordinate to complete a competitive application for the SAMHSA-sponsored CCBHC Planning Grant. HCPF and BHA preparation and planning meetings began monthly but ramped up heavily once the short application window was released, nearly reaching a daily rate, through collaborative strategy meetings, cross-agency executive leadership check-ins, monthly stakeholder forums, and ad hoc informal meetings. All application materials, support materials, and a HCPF CCBHC website were approved by both HCPF and BHA leadership. This joint effort led to the successful completion and submission of the planning grant.

Operational Partnerships: The Non-Medicaid Behavioral Health Eligibility and Claims System project leverages existing HCPF infrastructure by BHA and supports the state's ability to analyze data across agencies, offering a more comprehensive perspective on publicly funded behavioral health services and equity. This partnership helps the state ensure that BHA only uses its dollars for services that cannot be reimbursed by Medicaid, preserving precious general fund and flexible behavioral health federal and state funds. This technology partnership uses HCPF's existing technology infrastructure to reduce statewide administrative burden and costs of building separate BHA information technology (IT) systems. This will inform policy, payment and rates, and improvement strategies at various levels. In addition, will identify areas to maximize Medicaid draw down where appropriate.

In addition to the larger system alignment efforts, HCPF and BHA jointly participate in several ongoing public meetings, including:

- BHA and BHASOs have been incorporated into the membership and leadership of the collaborative forum to support youth involved in the child welfare system called the HRC2B2 (HCPF, RAEs, CHDS, counties, BHA, BHASOs). In this forum, BHA helps select the agenda, presents topics, solicits feedback and provides input on any issues that impact the child welfare system. The HRC2B2 forum also has associated workgroups such as the Assessment Workgroup where BHA and current Administrative Service Organization (ASO)

[4] hcpf.colorado.gov/sites/hcpf/files/7.5.23%20MCR%20Final%20Service%20Definition%20%281%29.pdf
[5] drive.google.com/file/d/14miYUWAh8NcPEUAKnNS7L8i2o_gzkWXv/view

staff are actively working to increase alignment between systems (Medicaid, child welfare, and Children and Youth Mental Health Treatment Act).

- BHA facilitates a workgroup to improve the independent assessment process for youth in foster care. BHA and HPCF staff coordinate agendas and tasks to ensure efforts are aligned and to avoid duplication.
- ACC's Program Improvement Advisory Committee (PIAC) is the regular public stakeholder advisory structure for the ACC program. Currently, BHA has a seat on the behavioral health subcommittee, BHA joins PIAC to present topics of shared interest (such as explaining the similarities and differences between RAEs and BHASOs), and representatives of current ASO/future BHASO serve as committee members.
- HCPF and BHA collaborate regularly on more narrow program management items such as implementing reimbursement for room and board in residential treatment per HB24-1038. Collaboration on these items happens via multiple channels such as the forums listed above, BHA staff joining ACC operational meetings, and state technology solutions (email, Google Chat, shared document editing etc.).
- HCPF and BHA also collaborate regularly for member specific items under the Child and Youth Consulting Staffing meetings. HPCF management meets with BHA and CHDS child welfare management to support members whose needs are extremely complex and/or difficult to address. These state staff work to ensure all available resources, regardless of the program, are used effectively.

25. [Sen. Kirkmeyer] How many state and contract employees are in the Behavioral Health Initiatives and Coverage Office? How many new positions were created when the Office was created? What is the administrative budget of the Office?

RESPONSE

HCPF administers the largest health plan in the state – Health First Colorado, covering about 1.3 million members, about 1.8 million last fiscal year, through Medicaid and CHP+ at its higher point. It also oversees several other safety net programs – school based health care, senior dental, buy-in, Cover All Coloradans, Family Planning, etc. As a reminder, HCPF is structured by Offices. Other departments may call them Divisions. HCPF's Offices reflect "functional" support areas as well as "product" support areas. Examples of functional support offices include the Finance Office (which houses budget, fee for service and capitated rates, our controller, auditing, procurement, value based payments, hospital reporting, provider fees, and non-Medicaid financing), Cost Control & Quality Improvement Office (which houses HCPF's clinicians, data and reporting, quality performance strategies and tracking, cost control contracts like utilization management, etc.), Medicaid Operations Office (claims payment, provider and member call centers, provider contracting and network tools, eligibility systems, etc.). Product or policy-related HCPF offices include the Health Policy Office (HPO), the Office of Community Living, and the most recent – Medicaid & CHP+ Behavioral Health Initiatives & Coverage Office. The Office Director is Cristen Bates.

When prescription drugs became the leading driver of rising health care costs nationally, specialty drugs were ballooning, and Medicaid's prescription drug expenses crossed the billion dollar mark, a Pharmacy Office was created. No additional FTE were hired to do so. The Pharmacy operations experts were simply centralized into an office to create more accountability and focus and an Office Director was identified as the accountable leader of the office to drive better results across affordability, access, and the like. A public report was prepared by the Pharmacy Office in 2019 and 2021 identifying the drivers of rising prescription drug costs and solutions to address them.

When customer service provided by Health First Colorado was called into question by stakeholders (phone system response for members and providers was poor and the claim system transformation occurred in 2017 which drove challenges, etc.), a Medicaid Operations Office was created to create more accountability and focus on service. Providers were defined as customers to transform the Health First Colorado culture and focus. Member and provider phone service metrics and claim turnaround time performance metrics were formalized, network provider recruitment and member digital tools were prioritized, etc. The results were transformational to the betterment of member and provider service. This office continues to drive improvements in service to the betterment of members, providers and our vendor partner performance as well.

When the Executive Branch and General Assembly prioritized the transformation of Behavioral Health, HCPF created a Medicaid & CHP+ Behavioral Health Initiatives and Coverage Office (BHIC) to drive accountability and a more effective structure to respond to the emerging demands of the General Assembly, the Executive Branch, providers, advocates and other stakeholders as part of the massive behavioral health transformational process that would unfold. **Zero** new HCPF FTE were added to form the BHIC.

HCPF projects that it will spend $5,362,297 total funds, including $2,361,826 General Fund, for 46.3 FTE working in the Behavioral Health Initiatives & Coverage (BHIC) office in FY 2024-25. This includes 11.0 FTE that are funded through the Home and Community-Based Services (HCBS) ARPA spending plan **and are term limited** through December 31, 2024, net 35.2 effective Jan. 1, 2025.

HCPF did not request any new funding to create the BHIC office; rather, the office includes staff that were moved from other HCPF offices to better align the behavioral health-related work as part of an organizational restructuring of HCPF. HCPF's personal services funds are not appropriated by individual office but rather to fund the costs to administer the Medicaid and CHP+ programs overall. All staff within the BHIC Office are authorized through the JBC and working on state and federally authorized programs. Influencing factors on creating the BHIC include:

- The need for accountable behavioral leadership within HCPF to appropriately respond to the increased state focus on Behavioral Health Reform, with the development of the BH Task Force, multiple Interim Legislative Committees,
- The passing of 38 behavioral health bills by the General Assembly from 2021–2024 impacting HCPF behavioral health.

- An increase in the number of state-based transformative initiatives, requiring coordination and collaboration across state departments such as CDHS, CDPHE, DOI, and BHA.
- Required improvements in coordination and collaboration with BHA, which required and lead to many changes in the BH system policies. HCPF needed to ensure alignment and expertise of staff was not limited to HCPF but also the BH system overall, as well as help educate BHA on HCPF policy and operations.
- Federal and state required expansion of BH benefits and federal approvals for programs in: mobile crisis, SUD residential, secure transport, criminal justice re-entry, supportive housing, peer and recovery services, community health workers, mental health inpatient benefit, RAE oversight and utilization management of BH services, 1115 waiver monitoring and oversight, new provider types and new payment models. Combining the staff, project management, and accountable oversight of these programs allows for more efficient use of staff resources.
- HCPF's Home and Community-Based Services American Rescue Plan Act funding, over $550M, focused specifically on serving individuals at risk of institutionalization, with over $130M in projects and funds focusing exclusively on behavioral health.
- The need for more focused accountability and sign off by a member of the senior executive team.

Every organization has to evolve and advance its structure to respond to the changing macro and micro environment. Not doing so would be out of line with organizational leadership principles.

PROSPECTIVE PAYMENT SYSTEM

26. [Sen. Kirkmeyer] What funding is required to fully implement PPS? How did the Department assess the funding need for PPS and whether current funding is sufficient?

RESPONSE

No additional funding is required to complete the implementation of the PPS. There is ongoing contractor funding for auditing purposes, but this is the same as the previous payment methodology.

HCPF did numerous analyses to show that the cost-based PPS methodology was cost neutral to the state compared to the previous cost-based methodology including a retrospective repricing comparison. Since the payment methodology is cost-based, HCPF added a requirement for reconciliation after the fiscal year to tie to actual, audited costs for comprehensive providers. This ensures that providers will be made whole through the first two years of the transition to PPS. After that, comprehensive providers will be at risk, as they were under the previous methodology. The providers were also provided with a rate trended to the future time period, something that did not exist for the previous payment

methodology. Additionally, a risk corridor for these services exists between HCPF and the RAEs to enforce appropriate payment. This is all encompassed in current funding and ensures sufficiency.

27. **[Sen. Amabile] Because providers are paid based on daily encounters, are providers incentivized to have patients return multiple days in a row rather than scheduling multiple services in one day? Please describe the anticipated benefits of PPS. Who is the system supposed to be better for, patients, providers, RAEs, or the Department?**

RESPONSE

Yes, there is an incentive with a daily visit-based rate, usually known as an "encounter" rate, for providers to maximize the number of visits to increase payment. While this is a known risk of a cost-based encounter rate system, other payment systems also have risks. For example, a monthly payment could incentivize a provider to see members as infrequently as possible. In Colorado, the community and member feedback has made clear that safety net policies need to prioritize individuals with chronic, serious, and complex behavioral health needs. Between the two options, daily or monthly, the daily rate incentives to see and support individuals who need regular engagement is higher than a monthly rate. That includes those with serious mental illness, chronic or co-occurring substance use disorder, and individuals who need a high level of case management due to housing and criminal justice involvement.

HCPF believes the risk that providers inappropriately spread visits out over multiple days to maximize billing is relatively low. This type of billing practice could be fraudulent, and providers would be at risk of repaying the funding plus damages. There may also be criminal liability. In addition, if the provider tried to increase the number of encounters to increase revenue, but the total costs stay the same, then their PPS rate would go down; this further reduces the incentive for a provider to maximize visits. Finally, in the first two years of implementation, the PPS rates will be recalculated after total cost and visit information is known; if a provider artificially increased visits, this recalculation would force a rate decrease that would trigger repayments.

HCPF will monitor the effects of the implementation of the PPS rates over time to ensure that it does not cause unintended access issues or inappropriate increases in expenditure. HCPF also does not have any data suggesting that comprehensive providers (previously called CMHCs) were previously providing multiple services in one day as a standard practice.

The anticipated benefits of a daily PPS rate are that they create stability and predictability, while remaining flexible. The Nation Council for Mental Wellbeing states, "PPS in its many variations provides a critical financial foundation across the safety net and deserves continued support from policymakers" and additionally offers that for a monthly PPS, providers experience more downside risk than in a daily model. This is because rates are set based on the anticipated volume of services for that month, and clinics may experience a

financial loss if costs for services incurred in that month exceed expectations. This could occur if a patient experiences a crisis in that month due to a poorly controlled condition.[6]

The daily PPS is designed specifically to benefit the members. Over time, there is no incentive for the provider to withhold or prolong care, since they are paid their costs either way. The PPS is supposed to provide stable and reliable funding so that comprehensive providers can design care plans around the needs of an individual, not around the service that pays them the most. This improves access to care, especially for members with chronic and serious behavioral health needs.

There is an additional benefit to both the RAEs and the providers in that the PPS rate acting as floor removes the need for extended contract negotiations or Single Case Agreements. This will mitigate payment issues between the RAEs and comprehensive providers.

28. **[Sen. Kirkmeyer] Are RAEs required to contract with comprehensive providers designated by the BHA? How can a safety net system be established if RAEs are not required to contract with providers designated by the BHA?**

RESPONSE

Yes, RAEs are currently required to contract with Comprehensive Providers, and that requirement will continue in ACC 3.0. HCPF considered removing the requirement for the RAEs to contract with any specific provider type, including federally designated Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Comprehensive Providers – all of which are paid cost-based rates. However, HCPF determined the contract change was not necessary during a time of uncertainty for many safety net providers.

The following current contract language will be retained in the RAE contract for ACC Phase III:

> *Contractor shall offer contracts to all willing and qualified FQHCs, Comprehensive Providers, RHCs, and Indian Health Care Providers located in the Contractor's assigned region(s).*

BHA supports this decision as it achieves goals shared by HCPF and the BHA, including creating aligned BHASO and RAE provider networks where possible, and aligning incentives for safety net providers to serve Medicaid and uninsured populations.

YOUTH SYSTEM OF CARE

29. **[Sen. Bridges] What work is the Department doing to keep the General Assembly and general public informed on the plan for responding to the GA v. Bimestefer settlement agreement, implementation updates, costs, and outcomes? How will the Department's plan actually solve structural challenges in the state?**

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[6] "Certified Community Behavioral Health Clinics: A New Type of Prospective Payment System." https://www.thenationalcouncil.org/wp-content/uploads/2022/06/CCBHCs_A_New_Type_of_PPS_3-2-20.pdf.

RESPONSE

Part One:

The Department of Health Care Policy and Financing (HCPF) originally communicated the GA v. Bimestefer settlement agreement in April of 2024 with a news release and posting the settlement online. Since then, HCPF has taken several steps to keep the general public informed on the plan for responding settlement agreement, including conducting a statewide tour in August and September 2024, gathering input from partners across the state through in-person sessions in 15 cities and towns, along with dozens of virtual meetings. In collaboration with Mental Health Colorado (MHC), HCPF also hosted three lived-experience groups, both in-person in Denver and Grand Junction and virtually, to help inform the plan. In addition, HCPF is creating a recurring newsletter and webpage with updated information. Since stakeholder feedback is critical to the success of developing and executing the settlement agreement plan, HCPF will utilize a multi-stakeholder committee structure moving forward.

As part of House Bill 24-1038, HCPF established both the Implementation Advisory Committee and the Statewide Leadership Committee. The Implementation Advisory Committee, formed in September 2024, is composed of advocates, counties, providers, RAEs, state agencies, and people with lived experience. The Implementation Advisory Committee will meet bimonthly to monitor progress and provide guidance on gaps in establishing the System of Care for high-acuity children and youth.

The Statewide Leadership Committee, formed in October 2024, will meet quarterly for the decision-making and oversight of the System of Care for children and youth who have complex behavioral health needs. The committee is composed of leadership from state agencies, statewide advocacy organizations, providers, county commissioners, and representation of individual(s) with lived experience.

Additionally, an advisory committee will be created in conjunction with MHC that is focused on the lived experiences of members and their families. The Lived Experience Advisory Committee will be composed of Medicaid members and their families and is intended to ensure the voices and perspectives of members and their families with current or past lived experiences with the behavioral health system of Colorado are heard in the successful implementation of the System of Care. This committee will share recommendations and feedback on their experiences accessing services and ways to improve the system.

HCPF has heard the JBC’s request for an executive session to be updated on the Settlement Agreement. HCPF will be happy to discuss greater details of this process as it relates to the Settlement Agreement with the committee.

Part Two:

The Department of Health Care Policy and Financing’s settlement agreement plan addresses structural challenges in the state by having services delivered in a system of care framework, including adding new service, family supports, and wraparound services for children and their families. A system of care structure utilizes an intensive care coordinator to work with the family to bring together all the providers, agencies, and organizations working with the

member and their family. The coordinator serves as a resource for the family in navigating different systems (health and non-health systems) and centralizing the varying treatment plans across agencies. A system of care involves the coordination of intensive services. It is an evidence-based approach that reduces unnecessary emergency department visits, out-of-home and out-of-state placements, length of time spent outside of the home, re-entry into higher levels of care and involvement in the juvenile justice system. The plan HCPF is working on with the BHA centers around the development of a system of care that will increase access to intensive in-home service for Medicaid members under the age of 21 by:

- Having a centralized point of contact across all providers through an intensive care coordinator that will lead the development of a single care plan for the family.
- Utilizing High Fidelity Wraparound as the intensive care coordination model to serve young people and their families with acute needs, specifically Wraparound will:
    - Take a collaborative, team-based approach that focuses on the individual's strengths and needs,
    - Involve their family and community support system in the decision-making process,
    - Create a personalized plan that addresses all aspects of their life and is regularly reviewed and adjusted based on progress and needs of the member and their families, and
    - Coordinate services from various agencies to ensure comprehensive care, ultimately leading to better outcomes and improved quality of life for the individual receiving treatment.
- Creating statewide uniform processes and tools that will identify members that need more intensive services and highlight the needs of the young person and their family.
- Increase access to child and youth clinical expertise in the current crisis system.
- Increase access and availability of intensive in-home treatment so children can receive the level of care they need without being removed from their home.
- Increase access to support services, which are services that are needed for the member and their family to successfully engage in treatment and increase the effectiveness of the clinical intervention.

In addition, HCPF is working with the BHA and other partners to formulate a plan for workforce capacity development – structurally Colorado does not currently have the workforce capacity to implement a system of care model. As part of its settlement agreement plan, HCPF will be developing solutions to address workforce challenges that have prevented access to intensive in-home services.

30. **[Sen. Amabile] Please describe the population the Department anticipates to serve under the system of care responsive to the GA v. Bimestefer settlement agreement. How many youth are in this population? Are we creating service cliffs based on age, diagnosis, or Medicaid eligibility?**

RESPONSE

In the *G.A. v. Bimestefer* settlement agreement, the population is defined as "children under the age of 21 who are enrolled in Colorado's Medicaid program and who have been diagnosed with a mental health or behavioral disorder and for whom [intensive behavioral health services] have been determined to be Medically Necessary."

HCPF is still in the process of working with the plaintiffs on the population scope; however, knowing that a system of care helps children and youth with high acuity needs, HCPF identified that last calendar year, there were 10,457 Medicaid children and youth who received at least one of the following services:

- Multiple Emergency Department visits for Behavioral Health within 12 months
- Inpatient Behavioral Health
- Intensive Community Based Service
- Day Treatment Services
- Inpatient Substance Use Disorder Service
- Residential Treatment in either a Psychiatric Residential Treatment Facility (PRTF) or Qualified Residential Treatment Program (QRTP)
- Residential Substance Use Treatment
- In foster care and receiving behavioral health services

The Medicaid System of Care is designed around services and supports that evidence-based studies have shown to be effective for treating high-acuity children's and youths' mental health needs. As part of the continuum of care, the Managed Care Entities/Regional Accountable Entities will have an active role with all Medicaid children and youth served through the Medicaid System of Care. This will help to ensure continuity of care as children and youth transition out of the Medicaid System of Care into other medically necessary behavioral health treatment such as traditional outpatient, medication management or other intensive adult services.

The Medicaid System of Care model is just one part of the continuum of behavioral health services for all individuals and is not meant to replace interventions for adults who require behavioral health services. For adults, there are various existing models utilized by comprehensive safety net providers, such as Assertive Community Treatment, to provide intensive services in the community. Research, clinical best practices, and voices of individuals and their families all are very clear that children with complex needs need a system designed specifically for them. For example, First Episode Psychosis programs through the BHA, Early Childhood Mental Health Consultation through the CDEC, and School-Based programs through CDPHE, are all child-specific behavioral health programs built around systems that serve children. Adult systems and supports are focused more on crisis intervention, community outreach, partnership with hospitals and primary care, employer wellness programs, jail-based programs, and self-directed recovery programs that are connected to adult systems. HCPF recognizes that there are gaps in programs across adult systems that could benefit from connection and is working on building out these connections by addressing health related social needs, expanding peer and community connector services, and working with RAEs and others to improve transitions across systems.

31. **[Sen. Kirkmeyer] The BHA has developed a Child and Youth Behavioral Health Implementation Plan, and is contracting with the group that assisted with development of a system of care in New Jersey. How does current work at the BHA overlap with the Department's response to the GA v. Bimestefer settlement agreement? How is the Department coordinating with the BHA on an ongoing basis to ensure there is not duplication, or gaps in service, specific to developing a youth system of care?**

RESPONSE

The Behavioral Health Administration's Child and Youth Behavioral Health Implementation Plan highlights the steps taken by both HCPF and BHA to co-lead the development of the system of care framework that is used to create the structure for service delivery in the Implementation Plan required for the GA v. Bimestefer Settlement Agreement. It is the goal of both agencies to use the same system of care structure, standards, and interventions for delivering services. The key difference between agencies is related to payor source, with HCPF responsible for families that are Medicaid eligible.

System of Care is a subpart of the care continuum outlined in the BHA Child and Youth plan. The care continuum is for all behavioral health services for children and youth and the System of Care is an approach to coordinate intensive services for young people with acute behavioral health needs specifically. To ensure that a unified system of care framework is being developed, the BHA and HCPF have co-led the development of a System of Care for consideration to the Plaintiffs in G.A. v Bimestefer, community partners, and county agencies. The proposed plan includes intensive in-home services, the standards of care for those services, policies for accountability and protocols so families can access services, and an overall vision for how it is executed. Both agencies' leadership confer no less than weekly on the progress of the System of Care plan and prepare it for review by the plaintiffs, partners, committees, and general public. In addition, the BHA and HCPF have decision makers on the HB 24-1038 Implementation Committee and Leadership Committee.

32. **[Rep. Sirota] The state of New Jersey appears to contract with a single third-party creates a no wrong door/single point of entry for care navigation statewide, compared to divided responsibilities between RAEs, BHASOs, providers, and Departments in Colorado. Wouldn't a single point of entry be more effective for patients? How far is Colorado from having a single point of entry for care navigation regardless of age, insurer, region, and diagnosis?**

RESPONSE

New Jersey's System of Care was implemented in 2001, which was lawsuit driven. They have had over 20 years to establish and upgrade their current System of Care. New Jersey is a state with managed care. In addition, New Jersey uses a single third-party entity called PerformCare New Jersey, which is not an entity specific to Medicaid. Youth who are eligible

for services through PerformCare are primarily between the ages of 5 and 21, reside in the State of New Jersey, have an emotional or serious mental health or behavioral need, and the services have been determined necessary by means of an assessment.

There is no charge for calling PerformCare. The services they recommend are authorized without regard to income, private health insurance, or eligibility for Medicaid or other health benefits programs. When the child is registered for services at PerformCare, the family will be asked to provide details about their insurance coverage.

Access to services provided under the NJ System of Care requires the family to complete a Medicaid application. In doing so, the family may be found eligible for Medicaid as secondary insurance, or the child may be approved for state funds that cover the cost of certain behavioral health services to supplement your private insurance benefits.

HCPF and BHA share the values of PerformCare, specifically that the burden for navigating the health system should be on the organization serving the family and not the family themselves. In addition, both departments want to avoid telling families they are not in the right place and be of no assistance, which is why both agencies have worked together to strengthen contracts to offer assistance regardless of which health plan the family is enrolled. Specifically, RAE and BHASO contracts, starting July 1, 2025, will have language about providing warm transfers between agencies depending on if a person is Medicaid eligible or not.

To maximize alignment and efficiency, HCPF and BHA collaborated on the launch of ACC 3.0 and the launch of the BHASOs. We have aligned the four BHASO and RAE regions to promote greater whole system alignment, and the BHASOs will enter into formal agreements with RAEs to establish coordination and cooperation among BHASOs and RAEs. These agreements will include:

- Policies and procedures to ensure continuity of care for all individuals transitioning into or out of Medicaid enrollment, preventing disruption or delay to an individual's services.
- Data sharing and privacy policies for individuals transitioning onto or off of Medicaid, as well as those who are receiving coverage from both BHASOs and RAEs simultaneously.
- Definition of roles in Care Coordination to reduce duplication.
- Methods to leverage resources within Medicaid and BHA to optimize funding for needed services.
- Procedures to monitor equity and outcomes within the region and share data with one another.
- Procedures to report and share quality information relevant to monitoring the provider network.
- Methods to support provider quality improvement through shared or coordinated training, grievances, and technical assistance.

It is with these values that HCPF and BHA want to create a no wrong door approach for families accessing care.

There are different approaches to easing access to care for families. New Jersey has developed a 'single entry point for all families' approach which is funding at approximately 60% state fund model. HCPF and BHA authority and legislative directives are to build upon the infrastructure that currently exists and move towards a no-wrong door approach with RAEs in ACC 3.0 and BHASOs. For the state to shift to a consolidated single entry (PerformCare) approach would require significant revisions to statute and state funding to implement. Since New Jersey has a single department over Medicaid, behavioral health, and human services, the structure allows for some additional levels of financial coordination across federally funded state-administered programs.

HCPF and BHA are moving forward with making meaningful, iterative changes to the system following the direction provided through legislation and extensive stakeholder input. This is reflected in improvements to its approach with new expectations and standards for RAEs and BHASOs starting on July 1, 2025, to strengthen the no wrong door approach. HCPF is working with BHA to ensure that there is no wrong door for Coloradans to enter the behavioral health system.

33. **[Sen. Bridges] What is the total estimated cost to implement the Department's system of care plan in response to the GA v. Bimestefer settlement agreement, and how will the Department leverage existing resources and federal dollars to implement the plan?**

RESPONSE

As the current implementation plan is still in development and needs to be approved by the Plaintiffs, the exact cost for a system of care is currently unknown. HCPF will be happy to discuss greater details of this process as it relates to the settlement agreement with the committee.

HCPF does know the estimated cost of other systems in other states based on the population that is served and the utilization rates for each of the services in their System of Care. Some states, such as New Jersey and Ohio, take a "serve-all-children" approach and their System of Care is not limited to Medicaid members under the age of 21 with acute behavioral health needs. New Jersey and Ohio's systems are both estimated to be in the magnitude of a billion dollars each. Illinois's System of Care is not as expansive as the population range that New Jersey and Ohio serve. Since Illinois is under a legal process, their information is not yet publicly available.

HCPF will leverage the maximum federal matching funds available for all allowable costs. HCPF anticipates, as evidence shows, that an increase in intensive services in a system of care structure will decrease the use of costly services such as hospitalization and residential treatment and allow children and youth to be served in their communities. HCPF will work with CDHS to monitor the impact the System of Care has on the utilization of residential treatment and determine if and how investments in the System of Care result in a reduced need for other types of care. In addition, HCPF has been working with the BHA to collaborate on utilizing both Medicaid and BHA funds to increase workforce training and capacity for System of Care services. The plan will require new services and programs, in addition to what

is currently funded across agencies. The cost of the program will depend on which services are included and the population identified.

34. **[Sen. Kirkmeyer] Has the Department entered into a contract to evaluate PRTF rates as directed by HB 24-1038 (High Acuity Youth)? When does the Department expect to know the result of the evaluation? If the evaluation is complete, what were the results?**

RESPONSE

HCPF has finalized a contract amendment with Optumas to have the contractor complete the actuarial analysis, but the evaluation is not complete. The contract amendment was finalized at the end of December 2024 and HCPF will have a completed evaluation no later than June 2025. Once we have the results we will share the report.

INTEGRATED BEHAVIORAL HEALTH SERVICES

35. **[Rep. Bird] Please describe any work the Department has done to determine the impact to providers and patients to transition to HBAI. Are providers supportive of the transition? Will it improve service to patients, or is a longer assessment necessary for sufficient attention to patient need? Is the transition to HBAI driven by reduced costs or better care?**

RESPONSE

Coding guidance published by the Advancing Integrated Mental Health Solutions (AIMS) Center out of the University of Washington identified the Health Behavior Assessment and Intervention (HBAI) codes as fitting and effective for supporting Integrated Care programs. The HBAI codes are designed for a primary care context by allowing for brief assessments and interventions using 15–30-minute codes that can also be "stacked" to accommodate the total amount of time a behavioral health provider spends with a patient. These codes allow for more flexibility in an integrated care context and can be used for individual, family, or group interventions. Additionally, these codes are accepted by many commercial carriers as well as Medicare. Aligning provider claiming and reimbursement activities between payers was a key factor informing this approach. The request to open HBAI codes is supported by the HB 22-1302 Medicaid grantees and Medicaid primary care providers.

The design of the Integrated Care Benefit, which would include the HBAI codes, is intended to increase access and provide more appropriate care in an integrated primary care setting. By opening codes with shorter time limits to fit within the workflow of a medical clinic organized by 15-20 min appointments, the HBAI codes will support integration more effectively than the current short-term behavioral health benefit.

As Colorado observed from the State Innovation Model (SIM), and as accepted in integrated care literature, integrated care is better for patient access and outcomes and results in system cost savings over time. Care Integration is considered a cost savings model as it can

reduce emergency department utilization, provide early intervention, improve patient wraparound care, help manage chronic conditions, and can streamline cross care coordination in different settings.

HCPF has used in-person and virtual visits to engage with 114 individuals representing 53 organizations during stakeholder engagement on the Integrated Care proposal. Stakeholders have been supportive of opening these codes as well as an array of other codes for HCPF to consider including in the Integrated Care Benefit. HCPF is entering a phase of stakeholder engagement in January related to the larger Integrated Care Benefit policies that include sunsetting the Short-Term Behavioral Health (STBH) benefit. Multiple stakeholders also expressed support for adding an incentive payment through the form of a per member per month payment to integrated care practices, in addition to opening these new codes. However, the R-12 request was designed to have limited impact on cost while still increasing access to care and supporting providers.

36. **[Sen. Kirkmeyer] Please describe how ARPA funds from HB 22-1302 have been utilized. What amount is unencumbered? How many grants or contracts have been awarded? How have grant funds been utilized by providers to increase access to integrated care?**

RESPONSE

HB 22-1302 selected 82 awardees, spanning 140 clinical sites in 33 counties across Colorado, to either implement new or expand current integrated care efforts within their clinic. 100% of these grants have been contracted and awardees are invoicing funds. Funds have been allocated to recruit staff for the implementation of integrated care or to enhance existing staffing levels, including behavioral health providers, psychiatric nurse practitioners, and care coordinators. Additionally, several sites have expressed a need for extra space to accommodate behavioral health providers or to remodel existing clinical areas to facilitate care. Upgrading electronic health record systems and electronic equipment has also been necessary, in addition to staff training to adapt clinical workflows and ensure the delivery of effective integrated care.

All grant contracts were finalized by February 1, 2024. As of July 1, 2024, all 82 grantees demonstrated progress within their approved scope of work. In the first quarterly report for FY 2024-25, 45% of sites self-reported their progress as on track, 40% indicated they were slightly delayed, and 15% reported a status of delayed. Many practices identified that delays were due to a shortage of available workforce, especially in the rural and frontier areas. Of the sites that requested funding to hire licensed behavioral health (BH) staff (42%), approximately 9% have successfully hired. The HCPF Integrated Care Team and the technical assistance support teams from the University of Colorado are collaborating with sites to adjust budgets for optimal spending of granted funds, focusing on telehealth contracts, BH support like care navigators, and other necessary adjustments. Maintaining flexibility to adjust funds across allowable costs is essential to addressing some of the workforce challenges identified. Analysis of grantees is ongoing, and the next update is slated to be released in a legislative report in 2025.

The total budget provided for HB 22-1302 was $34.75 million. As of November 30, 2024, a total of $33.08 million has been obligated: $15.81 million has been spent and $17.27 million obligated (encumbered and unspent) to the clinical sites. This leaves $1.67 million remaining, which is allocated for FTE through December 31, 2026, for a total of $34.75 million. All funds are targeted to be fully spent by December 31, 2026.

37. **[Sen. Bridges] Why are providers just now identifying that the existing billing structure is not sustainable? Why was the original structure selected, and what changed to make it unsustainable for providers? Did providers accept ARPA grant awards from HB 22-1302 knowing the long-term plan was not sustainable?**

RESPONSE

HCPF implemented the 6 Short-Term Behavioral Health (STBH) Benefit under the second phase of the Accountable Care Collaborative (ACC) in 2018. While this benefit was not intended as an integrated care benefit, practices and providers turned to it for integrated care as there was a lack of alternatives.

The STBH benefit uses standard psychological evaluation and traditional psychotherapy codes to provide access to short-term episodes of care for low-acuity conditions in a primary care setting. Between FY 2017-18 and FY 2022-23, the STBH Benefit has been underutilized with an average of about 1.3% of RAE members using this benefit, and 68% of utilization happening in Federally Qualified Health Centers (FQHCs).

Stakeholders have spoken strongly about the shortcomings in the current state of integrated care. The STBH Benefit billing codes do not cover briefer assessments or interventions, and therefore, many services are not currently reimbursable. Additionally, more complex patients often need more than the 6 visits offered under this benefit. These were known limitations of the STBH Benefit.

Stakeholders commented on the need for an integrated care reimbursement approach that supports better integration, closer collaboration between behavioral and physical health teams, and a funding approach that was aligned with the clinical context of a primary care setting. HCPF has received regular requests from providers and advocates over the last several years to open for reimbursement both Health Behavior Assessment and Intervention (HBAI) codes and Collaborative Care Management (CoCM) codes since these are designed more specifically for integrated care models. Additionally, traditional psychological evaluation and psychotherapy services are not standard integrated care interventions.

The Steering Committee and efforts exhibited by each clinical site have been key contributors to identifying the gaps and opportunities for state coverage outlined the Sustainability Report mandated by legislation, scheduled to be submitted to the Legislature in early 2025.

38. **[Sen. Amabile] Why is there a cost associated with integrated care when it should be saving the State money?**

RESPONSE

Integrated care is an umbrella term that is inclusive of multiple interventions provided to a client by a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. Overall, there are varying levels of integrated care, and in HCPF's Integrated care programs we have identified some of the reasons that we have seen historically lower than expected utilization of these services, and worked with providers to identify solutions. HCPF's Integrated Health Care request consists of three initiatives aimed to improve integrated behavioral health care in the primary care setting: adding Health Behavior Assessment and Intervention (HBAI) codes; adding Collaborative Care Management (CoCM) codes (both code sets to be billed Fee-for-Service (FFS)); and moving the psychological assessment and psychotherapy codes currently covered under the Short-Term Behavioral Health (STBH) benefit under the behavioral health benefit managed by the RAEs.

HCPF anticipates that adding HBAI codes and adjusting the existing STBH Benefit coding will result in a net decrease in costs of $1,364,107 total funds including a reduction of $318,797 General Fund. HCPF anticipates a decrease in costs for these two initiatives due to providers shifting utilization away from the existing higher cost STBH Benefit codes to the lower cost HBAI services primarily driven by the time requirement distinctions between the code sets. For example, if providers only have the choice of providing 45- or 60-minute interventions they will use those interventions. But having the option of 15-minute code is preferable for fully integrated practices, for workflow and patient access to services.

HCPF anticipates adding the CoCM codes will result in an increase of $2,939,474 in total funds including $686,967 General Fund due to an increase in services that previously have not been covered by Medicaid. Adding CoCM services in a primary care setting is anticipated to both increase services provided to members receiving care in a primary care setting and decrease inpatient psychiatric care and emergency department visits for members who are connected to their primary care doctors. While adding CoCM services would expand psychiatric access to members, especially in rural areas, the benefit utilization would be limited by the low availability of psychiatric providers. According to HRSA's Health Professional Shortage Area data, Colorado's current psychiatrist availability only meets 34.2% of the need. Expanding CoCM would continue HCPF's efforts to expand integrated health care access. HCPF did not include long-term savings assumptions in this request, but through several randomized control trials expanding access to integrated care results in long-term health care utilization and

improved treatment.[7] Additionally, HCPF found research that indicates that CoCM results in savings in the outpatient hospital setting, which was not included in this request.[8,9]

Overall, adding CoCM services increases costs while the combination of adding HBAI and shifting the STBH health codes results in a decrease in costs. The net effect of the request is an increase in costs of $1,575,367 total funds including $368,170 General Fund.

BUDGET REDUCTION OPTIONS

39. [Sen. Bridges] Please respond to the budget reduction options presented by the JBC staff, highlighting those that are most or least problematic.

RESPONSE

HCPF would like to work with the JBC to identify opportunities to control trends across Medicaid to the betterment of long-term benefit, eligibility and provider reimbursement sustainability.

Reduction Idea	Comment
Convert nursing home provider fees to enterprises	Not problematic: Converting the fee would not impact eligibility or services. The only concern is whether there is a legal way to create the enterprise in statute.
Redirect HAS Fee from supplemental payments for hospitals to instead offset General Fund	Not problematic: Redirecting the HAS Fee for General Fund offset in Medical Services Premiums would not impact eligibility or services.
Eliminate the statutory 1.5% increase for nursing facilities	Problematic: The 1.5% increase was negotiated as part of a larger agreement to remove the previous 3.0% increase in statute before HB 23-1228 was passed. This increase recognizes the ongoing needs of nursing

[7] Medicine (Baltimore). 2022 Dec 30; 101(52): e32554. Published online 2022 Dec 30. doi: 10.1097/MD.0000000000032554

[8] Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, Bauer MS. An Economic Analysis of the Implementation of Team-based Collaborative Care in Outpatient General Mental Health Clinics. Med Care. 2020 Oct;58(10):874-880. doi: 10.1097/MLR.0000000000001372. PMID: 32732780; PMCID: PMC8177737.

[9] Chung, Henry, et al. "Medicaid Costs and Utilization of Collaborative versus Colocation Care for Patients with Depression." Psychiatric Services, 24 May 2023, ps.psychiatryonline.org/doi/10.1176/appi.ps.20220604.

	facilities while also moving them closer to legislatively driven rate changes. This approach allows HCPF to more equitably and accurately set reimbursement rates for nursing facilities.
1% reduction in provider rates, excluding rates with a proposed targeted reduction	Between FY 2021-22 – FY 2024-25 across the board provider rate increases total 9.5% but compound to a 10% increase across impacted providers. Previous to these increases, which occurred when the federal government was releasing large economic stimulus dollars, the across-the-board increase totaled 6.27% for FY 2010-11 through FY 2019-20 (compounded), with an averaged 0.62%. Between FY 2021-22 – FY 2024-25, the General Assembly provided $434.5 million total funds in targeted rate increases, including $149.3 million General Fund, reflecting an average of $108.6 million total funds and $37.32 General Fund each year. These increases also established a new baseline, driving Medicaid trend. These targeted rate increases compare to a pre-pandemic average targeted rate increase of $20.0 million total funds, including $9.4 million General Fund. Given the atypical increases over the last several years, slight adjustment downward is an option.
Reduce dental, pediatric behavioral therapies, and rates above 95% of Medicare by 1% instead of (or in addition to) the proposed targeted reductions	The PBT provider rates have increased dramatically. A reduction in that increase would not be problematic. The Dental rates were also increased. Reducing them by 1% would be reasonable. A reduction of 1% across the board would simply mitigate the significant ATB increases made over the last few years. From FY 2021-22 – FY 2024-25 ATB increases totaled 9.5% but compound to a 10% increase across impacted provider types. This compares to far lower across-the-board increases of 6.27% for FY 2010-11 through FY 2019-20 (compounded), with an averaging annual increase of 0.62%.

Halt Medicaid and CHP+ look-alike for children lacking access due to immigration status, per H.B. 22-1289, scheduled to start January 2025	The program is set to be implemented on Jan. 1, 2025, and any reduction would reduce access to coverage for an estimated 15,050 undocumented individuals. Operationalizing a "halt" or a "cap" on the program will need to be discussed to include the effective date given the individuals already enrolled, and the timing of required systems changes necessary to implement a halt or cap. Emergency Medicaid covers care for life threatening conditions and would continue (paying providers, saving lives, covering labor and delivery, etc.). Cover All Coloradans covers preventive, general and acute care for pregnant people and children. Some providers are experiencing high impact self-pay/uninsured exposure due to the increasing number of uninsured undocumented individuals entering Colorado, such as Denver Health and FQHCs, especially in greater Denver. This recent U.S. immigrant surge is the highest since the 1800s.
Halt continuous coverage for children to age 3 and people to 1 year after incarceration, per H.B. 23-1300, scheduled to start January 2026	Since these coverage expansions aren't implemented until Jan 1, 2026, halting them is less disruptive. These expansions would ensure continuity of care and reduce churn. Reducing churn has positive impacts on patient health. Reducing churn also reduces eligibility administrative workload at the county level.
H.B. 24-1038 requires HCPF to expand CHRP eligibility and develop a system of care for high acuity youth. Repealing the bill would reduce General Fund in DHS by an additional $11.3 million.	Problematic: The funding from HB 24-1038 will be used to increase access to services for youth with complex behavioral health needs, in alignment with the settlement agreement for GA vs Bimestefer.
Halt prenatal coverage of choline supplements without a prescription, per S.B. 24-175, scheduled to start July 2025	Repealing coverage for choline supplementals would reduce access to a supplement shown to improve health outcomes; however, it is an over-the-counter supplement that members could potentially access otherwise.

Reinstate prior authorization requirements (PARs) for antipsychotic drugs that were removed, per S.B. 24-110, in FY 24-25	Not problematic/Requested: PAR criteria are established through clinical and comparative effectiveness, meaning that preferred and non-preferred statuses follow clinical evidence and guidelines to support informed clinical decision-making. This bill took away Medicaid's ability to ensure that best practices are followed to ensure member safety and caused a significant increase in Medicaid costs.
Halt reimbursements for community health services, per S.B. 23-002, scheduled to start July 2025	This service expansion has not yet been implemented, so repealing it would be less disruptive. However, repealing this bill could result in less access to preventive services in the future that could improve health outcomes for members; other ACC Phase III approaches could help offset that negative impact. It is unclear if repealing this bill would also impact CDPHE as SB 23-002 appropriated funds to update the Health Navigator registry.
Reinstate an annual cap on the adult dental benefit at $1,500 annually	Though this cap was in place at one time, removing the cap now potentially poses a legal risk. Second, dental care improves oral and physical health; therefore, implementing a cap would impact both. Further, the cap will be hit more quickly, impeding care, since higher provider reimbursement rates were implemented last year. If a cap were considered, perhaps further discussions on what level would be appropriate.
Eliminate the adult denture benefit	Problematic: Dentures are a crucial benefit for enrollees who need them as they help with chewing, esthetics, speaking, and securing employment. Removing the denture benefit would be detrimental to a person's quality of life, their ability to be a meaningful contributor to society via work and serious negative impacts to physical and mental health.

Eliminate (or cap) the reproductive health program for individuals not eligible for Medicaid program	Problematic: Medicaid pays for more than 40% of the births in the state, including undocumented births. Not providing birth control will increase births, which cost the state money. Eliminating the program would also result in reduced access to care; however, the program is currently spending less than the appropriated amount. If a cap were implemented, the appropriated amount could be reduced to achieve budget savings without reducing eligibility or services.
Halt reimbursements for remote patient monitoring, per S.B. 24-168, scheduled to start July 2025	This service expansion has not yet been implemented, so rescinding it is less disruptive. Repealing the remote patient monitoring program would reduce the projected increase in access to services, particularly in rural areas.
Halt coverage of continuous glucose monitors, per S.B. 24-168, scheduled to start November 2025	Not problematic: Halting the expansion of coverage to match Medicare criteria would not negatively impact access to care.
Eliminate CHP+ coverage of children and pregnant women from 206%-265% FPL and repurpose the HAS Fee savings to offset GF	Very Problematic: CHP+ currently covers over 90,000 children and pregnant/postpartum members (up from 37,000 during the PHE). CHP+ receives a higher federal match than Medicaid (65% vs 50%) and is more affordable and more robust than most marketplace or employer sponsored coverage. Eliminating coverage from 206-265% FPL would increase the number of uninsured children and pregnant women in Colorado.
Cap comprehensive services for adults with intellectual and developmental disabilities and don't fill positions that open through churn	The JBC has removed eligible individuals from the DD waitlist, enabling their coverage on the DD waiver. This has increased the number of individuals covered and propelled the trend accordingly. This practice could be mitigated for the next few years to mitigate LTSS trend. Authorizations for people who meet emergency enrollment criteria are specifically provided to stop or mitigate crisis situations thereby avoiding higher cost of care options such as hospital or institutional

	placements. Stopping emergency authorizations for enrollment into the DD waiver would be problematic. Churn enrollments, conversely, are authorized when a person's placement has come up on the waiting list for the DD waiver and would be less problematic to stop if needed due to the budget deficit. We are exploring the specifics of the Maintenance of Effort (MOE) requirements for the implementation of Community First Choice (the MOE is in place between July 1, 2025, and June 30, 2026) to avoid putting the state at risk of disallowance for federal match related to the program. We may be able to cap the aggregate of both churn and emergency enrollments, maintaining enrollment levels, or we may be able to cap churn itself if the overall HCBS spend is maintained. We are working on clarifying these options.
Halt rural grants for remote monitoring tech, per S.B. 24-168, scheduled for July 2025	Not problematic: The grants are one-time in nature and would not impact coverage of remote patient monitoring for members.
Eliminate training grants for screening and interventions related to substance use and repurpose the MTCF to offset General Fund	Eliminating the training funds would not impact coverage of screening and intervention services for members. Eliminating the grant funds will reduce access to the required training for providers and could reduce future access to early prevention SUD services.
Eliminate GF and matching FF for family medicine residency training programs	Reducing this funding would lower the amount of funding to train and develop the workforce, which could lead to a reduction in services in the long run due to lack of provider capacity.
Eliminate supplemental payments to Children's Hospital	Problematic: During COVID-19 financial challenges, this program was eliminated; however, it was then reinstated. Funds from this line enable expanded pediatric behavioral health capacity and are the only dedicated funding source for unique programs for kids with medical complexity.

Eliminate grants for dental care to seniors who do not qualify for Medicaid; there is no federal match	Problematic: Eliminating the grants would result in a direct reduction to dental service availability for low-income seniors.
Reduce contract services based on reversions of $5.7 million General Fund in FY 2023-24 and $1.5 million General Fund in FY 2022-23	Problematic: Recent reversions were due to a couple of large projects that were delayed, due to either waiting on federal approval or project timelines getting pushed back. In FY 2023-24, HCPF underspent appropriations for Cover all Coloradans by $4.5M GF and the Drug Importation project by $600k GF. We do expect those to fully spend down moving forward. Any reductions to the administrative funding for a specific program would need to be coupled with eliminating or reducing the program itself; otherwise, HCPF would be at risk of not complying with state and federal requirements to administer it.
Increased prepayment reviews will likely decrease improper payments	Not problematic/HCPF Requested: Expanding the contract for prepayment reviews would not impact eligibility or access to services for members but will result in appropriate state savings.
Reduce funding 20% for the Office of eHealth Innovations that provides technical support for technology to improve health information sharing	Problematic: A 20% reduction in funding would mean a decrease in personnel and state innovation efforts, including scaling back the rural connectivity program and the provision of other tools to help rural providers.
Eliminate subsidies for the All-Payer Claims Database that supports research using insurance claims	Problematic: Eliminating all funding to the APCD would be very problematic as it would result in eliminating the database, which supports bills passed by the legislature, impacting affordability, equity and quality. A reduction of the scholarship program only could impede research work for stakeholders but would not impact eligibility or access to services for members.
Eliminate County Incentive Program funding for performance incentives for county administration of medical assistance programs	Problematic: Some of the county funding is provided through incentives, designed to improve performance. Without this appropriation, HCPF believes there would be a significant impact to applicants and

	members navigating the county administered system. Elimination of this program would eliminate the performance standards HCPF has established for counties; these performance standards directly impact how quickly and accurately members can access medical assistance coverage.
1% reduction to state-only Programs budgetary subdivision	These state-only programs allow individuals with an IDD who are not on waivers due to waitlists or other qualifying issues to receive services in the community. Any cut would reduce the amount HCPF is able to support these individuals and is likely to have an undue impact on those waiting for services on the DD waitlist.
5% reduction to OCL personal services based on 6-year reversion history	Problematic: Any reduction to personal services would result in scaling back or delaying administration of HCPF's programs. HCPF fully spent the OCL personal services budget in FY 2023-24, especially given the current challenges OCL leadership and staff are working hard to address.
Reduction to OCL personal services to eliminate GF in excess of federal match	Problematic: HCPF is unable to draw down a federal match on personal services costs related to administering state-only programs. Reducing the General Fund in excess of federal match would result in a corresponding reduction in federal funds, as HCPF would need to continue to allocate costs to the state-only programs in compliance with the federal cost allocation plan.

40. **[Rep. Sirota] Please estimate the churn that implementing H.B. 23-1300 will prevent. Please describe the social and health care costs associated with the churn.**

RESPONSE

Please estimate the churn that implementing H.B. 23-1300 will prevent.

The state expects to impact thousands of adults and children with the proposed continuous coverage policies, eliminating or substantially reducing gaps in coverage (churn) among young children and adults leaving incarceration due to small or short-term fluctuations in income or incomplete renewal applications and other procedural terminations. Preventing this churn will reduce administrative cost and burden for the state, county departments of human services, and Medicaid members. Most importantly, continuous eligibility preserves access to care and promotes continuity of care in the critical early childhood period and for people leaving incarceration who are at risk of recidivism.

According to HCPF's analysis of enrollment data in 2018 and 2019, 20% of children ages zero to three with eligibility at any time in those two years experienced a gap in their Medicaid or CHP+ eligibility spans.[10] In implementing H.B. 23-1300, Colorado estimates that on average 31,000 children will receive continuous coverage.[11]

For individuals being released from Department of Corrections facilities, HCPF does not have a churn estimate. Annually, approximately 4,070 to 5,295 individuals are likely eligible for Medicaid upon release and will receive a full year of continuous coverage through H.B. 23-1300.[12]

Please describe the social and health care costs associated with the churn.

HCPF has not studied administrative costs associated with churn in Colorado and we have made significant progress on increasing the rates of ex parte, or automated, renewals that require no member or eligibility worker intervention. However, there are national estimates that show the administrative cost of one person churning once could be from $400 to $600 per incident and it is reasonable to conclude that some administrative savings would be achieved for those cases that do require manual intervention at renewal. [13] HCPF has found that in Colorado most gaps in coverage are short term and caused primarily by income fluctuations and documentation problems for both children and adults and may occur more often in rural and under-resourced communities.[14]

Children

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[10] Colorado Department of Health Care Policy and Financing. (2024) *Demonstration No. 11-W-00336/8: Amendment Request | 33.* Centers for Medicare and Medicaid Services. www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/co-continuum-care-pa.pdf

[11] ibid

[12] ibid

[13] Swartz K., Farley Short P., Roempke Graefe D., Uberoi N. (2015) *Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective.* Health Affairs. Retrieved from: www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[14] Center for Improving Value in Health Care (2021) *Understanding the Importance of Continuous Health Insurance Enrollment for Access to Care.* drive.google.com/drive/folders/1ZaGIcWTQSyo0Pmd0QlhAmrZwwJ_3ITTV

Children who experience gaps in coverage have a higher likelihood of unmet medical, prescription and dental needs, a delay in accessing urgent care and a lower likelihood of having a usual source of care and well-child care.[15] Ages zero to three are critical years for children's brain development, and gaps in access to health care during this period are particularly consequential. Early adversity, such as home-life instability, abuse, or illness can interrupt foundational brain development in the first years of life putting children at greater risk of developing lifelong health problems, including substance use disorders.[16] Through regular screenings, providers can detect problems faster in individuals, as well as their caregivers and home environments leading to earlier prevention and intervention efforts.

COVID-19 related disruptions in early childhood services and programs have a demonstrated impact on the positive development, and emotional and behavioral health of children and youth. In particular, young children from lower income households, single-parent families, and Black households, as well as young children with disabilities, experienced significant increases in emotional or behavioral problems, including depression.[17]

Continuous coverage for young children is an important tool to promote consistent access to health care and the preventive services needed to identify and address physical, behavioral, and developmental concerns before they impede a child's performance in school.[18] The administrative cost for enrolling, disenrolling, and reenrolling these populations leads to significant Medicaid expenses.

Adults

An estimated 80% of people recently released from incarceration have chronic medical, psychiatric, or substance use disorders and are 129 times more likely to die of an overdose

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[15] DeVoe, J. E., Graham, A., Krois, L., Smith, J., & Fairbrother, G. L. (2008) *"Mind the Gap" in children's health insurance coverage: does the length of a child's coverage gap matter.* Ambulatory pediatrics : the official journal of the Ambulatory Pediatric Association, 8(2), 129–134. Retrieved from: https://doi.org/10.1016/j.ambp.2007.10.003

[16] Ali N., Borgman, R., Costello, E., Cruz K., Govindu, M., Roberts M., Rooks-Peck, C., Wisdom, A., Herwehe, J., McMullen, T. (2022) Overdose Data to Action Case Studies: Adverse Childhood Experiences. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from: www.cdc.gov/drugoverdose/od2a/pdf/OD2A-ACEs-case-study-508.pdf

[17] Jones, K. (2021) The Initial Impacts of Covid-19 on Children and Youth (Birth to 24 Years): Literature Review in Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from: aspe.hhs.gov/sites/default/files/documents/188979bb1b0d0bf669db0188cc4c94b0/impact-of-covid-19-on-children-and-youth.pdf

[18] Brooks T., Gardner A. (2021) Continuous Coverage in Medicaid and CHIP. Georgetown University Health Policy Institute, Center for Children and Families. Retrieved from: ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf

compared to the general population in the first two weeks post-release.[19,20] A disproportionate number of incarcerated individuals are Black, Hispanic, and Indigenous, which compounds the existing health disparities affecting these populations and may result in greater physical and behavioral health needs than the general population.[21]

People who have experienced incarceration report challenges maintaining stability in the community, including losing Medicaid coverage soon after release as a result of obtaining employment. Further, individuals with substance use disorders or substance-related criminal charges who are reentering the community are at greater risk of criminal reinvolvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes and reduce future incarceration.[22] These challenges can lead to more hospitalizations and emergency department (ED) use than the general population. Individuals with recent criminal justice involvement make up 4.2% of the U.S. adult population, yet account for an estimated 7.2% of hospital expenditures and 8.5 % of ED expenditures.[23] For the general population, adults who have 12 months of Medicaid coverage have been found to have significantly lower average costs ($371/month) than those with fewer months of continuous coverage ($799/month for three months coverage).[24]

Since 2019, Colorado has seen increased engagement (from 9% to 20%) in behavioral health services by individuals being released from incarceration within 14 days of release.[25] Implementing H.B. 23-1300 for this population would ensure these gains are not lost, reduce the burden on the health care and correctional systems, as well as on individuals trying to regain stability and reduce inequitable impacts on people of color and the communities most affected.

41. **[Rep. Bird] How would reducing the Pediatric Specialty Hospital payments line item impact youth access to behavioral health services? Would reducing this funding increase our legal risk?**

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[19] Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," Health Affairs 36, no. 6 (June 2017): 1006–15

[20] Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65. doi: 10.1056/NEJMsa064115. Erratum in: N Engl J Med. 2007 Feb 1;356(5):536. PMID: 17215533; PMCID: PMC2836121.

[21] Binswanger et al (2007)

[22] NIDA. (2020) Criminal Justice DrugFacts. National Institute on Drug Abuse. Retrieved from: https://nida.nih.gov/publications/drugfacts/criminal-justice

[23] US Department of Justice Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12. January 2015. Available at: https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf

[24] Sugar S., Peters C., De Lew N., Sommers B. (2021) Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. Office of Health Policy Issue Brief. https://aspe.hhs.gov/sites/default/files/documents/5f6e4d78d867b6691df12d1512787470/medicaid-churning-ib.pdf

[25] Colorado Department of Health Care Policy and Financing. (2024)

RESPONSE
The Pediatric Specialty Hospital payment is a supplemental hospital payment HCPF makes to Children's Hospital Colorado (CHCO). Reducing funding does not inherently pose a legal threat to the state as this is a supplemental Medicaid payment paid to CHCO and CHCO has the authority to decide how the funds are distributed and for which programs.

However, based on the CHCO reported uses of these funds, reducing the Pediatric Specialty Hospital line item would have immediate, negative implications for access to care for children in Colorado in a way that could reduce access to care for the high acuity youth included in the G.A. v Bimestefer settlement agreement. CHCO uses funds from this line item to expand pediatric behavioral health capacity and this is the only dedicated funding source CHCO has for unique programs for kids with medical complexity.

CHCO reports that it uses the Pediatric Specialty Hospital payment to fund three discrete initiatives: The Medical Day Treatment Program; Expanded Outpatient Behavioral Health Services; and The KidStreet Program for Medically Complex Infants and Children:

- The Medical Day Treatment program works in partnership with Aurora Public Schools and other districts to ensure access to an educational placement alternative for children whose medical needs are too complex for them to attend regular school. CHCO is using $1.5 million in total funds for Medical Day Treatment in SFY 2024-25, covering the cost of 3,062 treatment visits and funding salaries for 7 FTE staff, including providers/medical staff and teachers for these children.

  Because the Pediatric Specialty Hospital line item is the only funding source for this program, its elimination would terminate the program, impacting access to education for children with complex medical needs.

- The Behavioral Health Crisis Outpatient Services Program increases access to urgently needed behavioral health services and avoids often costly and unnecessary behavioral health-related hospitalizations. The legislature expanded the Pediatric Specialty Hospital line item in 2014 as part of the state's response to the tragic Aurora theater shooting by strengthening access to behavioral health treatment. CHCO has substantially increased outpatient behavioral health volumes for high-need children and families, from a total of 12,890 visits in 2014 to over 41,000 visits in SFY 2023-24. Reducing or eliminating the line item would degrade behavioral health access and wait times for children covered by Colorado Medicaid, as it would arrest hiring for child/youth mental health providers and significantly slow efforts to match outpatient behavioral health capacity with community need. Losing this state funding could overwhelm community mental health centers, increase utilization of emergency departments, and increase demands for psychiatric inpatient hospitalizations.

- The KidStreet program is a one-of-a-kind early childhood education and child care program in Colorado for infants and children with medical complexity. KidStreet maximizes the health, well-being, and development of young children (ages 6 weeks to

3 years old) who are dependent on daily clinical interventions and medical technology by promoting independence for the patient and family, and by fostering peer interactions through the provision of a family-centered, multidisciplinary, Early Intervention program. The program allows the parents of these children to work and contribute to their communities while keeping their kids safe. KidStreet currently provides intensive services for 30 infants and children with medical complexity, with over 70 receiving services at KidStreet in the last year. Because the line item is the only dedicated funding source for this program – and the only Medicaid funding source allowable – its elimination would drastically impact the program, almost certainly triggering a major reduction or elimination. Without support of the daily program, many families with private insurance from their employers as their primary coverage may no longer be able to work and their health coverage would revert to only being covered by Medicaid due to the economic impact of losing access to a unique program like this.

42. [Rep. Bird] Please identify General Fund reversions from the Department's administration line items for the last five years and provide explanations for the largest reversions.

RESPONSE

The table below shows the reversions from the administrative line items with notes on those that have had significant reversions.

General Fund Reversion in HCPF Admin Lines						
Line Item	**FY19-20**	**FY20-21**	**FY21-22**	**FY22-23**	**FY23-24**	**Notes**
General Professional Services and Special Projects	$779,094	$3,040,887	$3,170,185	$1,487,391	$5,684,198	Reversions are due to a variety of factors, including receiving an enhanced federal match on some IT related projects, program implementation timelines getting extended. FY 2024-25 was primarily driven by delays in the implementation of Cover All Coloradans Health Services Initiatives funding.
Office of eHealth Innovation Operations	$803	$300,342	$1,076,035	$750,923	$502,699	Appropriation was set with a 50% federal match, but OeHI was able to leverage enhanced federal funding on projects. As more projects shift from a Medicaid focus to state-

						only, the reversions will continue to decrease.
Transfer to CDPHE for Facility Survey and Certification	$696,538	$795,462	$718,498	$734,254	$257,864	CDPHE has hired more FTE to utilize appropriation in recent years. Reversion is partly indirect costs.
Professional Service Contracts	$1,137,572	$0	$0	$1,669,166	$2,058,343	Delays in expanding the PAR program within the Utilization Management contract have pushed back the timeline to utilize this spending authority to future years. The expectation is minimal reversions in future years.
Public School Health Services Contract Administration	$317,755	$432,107	$577,402	$542,175	$373,328	During the PHE, program operations including travel and trainings, were reduced.
Contracts for Special Eligibility Determinations	$69,148	$113,366	$647,240	$410,644	$185,508	During the PHE, the PASRR program (Pre-Admission Screenings & Resident Reviews) were subject to federal directives to eliminate the pre-admission screenings.
Legal Services	$68,288	$0	$0	$1,195	$515,864	Expected litigation costs appropriated through FY 2023-24 S-07, "Community-Based Access to Services," were not needed due to mediation.
Payments to OIT	$0	$15,323	$1,186,402	$1,225,115	$1,408,144	OIT common policy adjustments double counted costs associated with OeHI and CBMS in this line as well as their operating lines. This was fixed in the FY 2025-26 budget submission so the expected reversion should drop considerably.

Work Number Verification	NA	$497,955	$587,130	$454,231	$450,276	Program leveraged CDHS's Equifax data contract and is a volume based contract. Actual volume came up short of estimates. HCPF now pays for CMS data for income verification out of this line item as well and expects the reversion to decrease.
Returned Mail Processing	NA	$745,155	$567,808	$387,800	$174,696	Program was new in FY 2020-21 and took a few years to ramp up. Funding pays for staffing and the program is close to full staffing levels.
Leased Space	$19,607	$55,277	$713,464	$513,127	$341,257	Savings are from temporary rate concessions that will eventually go away.
DHS Services Indirect Cost Assessment	$0	$3,223,091	$2,700,948	$4,567,375	$4,301,659	HCPF is in the process of reviewing this appropriation to more accurately align it to anticipated expenditures.
Third-Party Liability Cost Avoidance Contract	NA	$2,868,016	$4,074,295	$4,928,798	$0	Volume based contract that never hit expectations. HCPF adjusted spending authority downward through the budget process. Due to a vendor data issue and the ability for them to provide service during the FY 2023-24, roll forward was granted to pay outstanding bills.
Temporary Employees Related to Authorized Leave	NA	NA	NA	$2,411	$0	
Workers' Compensation	$76	$0	$0	$13,946	$0	
Administrative Law	$466	$0	$0	$34,492	$2,071	

Judge Services						
Payment to Risk Management and Property Funds	$85	$0	$0	$11,597	$0	
CORE Operations	$196	$0	$0	$0	$0	
Transfer to DORA for Reviews	$1,875	$1,875	$1,875	$1,875	$1,875	
Transfer to DOE for Public School Health Services Admin.	$22,826	$63,229	$5,628	$2,440	$4,127	
Transfer to DOLA for Home Modifications Benefit Administration	$140,198	$23,470	$1	$48,994	$63,209	
Transfer to DOLA for Host Home Regulation	$31,315	$0	$22,187	$19,061	$6,998	
MMIS Maintenance and Projects	$0	$0	$18,086	$0	$180	
Colorado Benefits Management Systems, Operating & Contracts	$1,150,267	$0	$0	$0	$0	
Colorado Benefits Management Systems, Health Care and Economic Security	$1,075	$116,488	$25,819	$0	$120,337	

Staff Development Center						
All Payer Claims Database	$1	$0	$0	$72,367	$243,308	
County Administration	$0	$0	$938,252	$0	$0	
Administrative Case Management	$0	$0	$0	$0	$135,076	
Customer Outreach	$358,172	$457,131	$401,103	$427,080	$118,909	
Eligibility Overflow Processing Center	NA	NA	$166,766	$76,629	$54,512	
Professional Audit Contracts	$494,398	$394,221	$284,504	$272,644	$198,889	
Community and Contract Management System	$58,571	$58,571	$57,942	$58,098	$56,491	
Support Level Administration	$8,959	$3,830	$3,956	$0	$0	
Executive Director's Office - Medicaid Funding	$167,475	$0	$1	$0	$0	
Division of Child Welfare Administration	$5,752	$1,932	$12,504	$15,237	$101,750	
Systematic Alien Verification For Eligibility	$467	$4,090	$3,583	$3,734	$1	

Community Behavioral Health Administration	$188,352	$21,985	$147,310	$89,580	$0	
Regional Centers Electronic Health Record System	$15,191	$154,419	$204,881	$160,690	$257,928	

43. [Sen. Bridges] Describe the Office of eHealth Innovations and the impact of a 20 percent General Fund reduction.

RESPONSE: The Office of eHealth Innovation (OeHI) is located in the Offices of the Governor/Lieutenant Governor and HCPF serves as the fiscal and administrative agent for OeHI. The Office is the State-Designated Entity for all health Information Technology (IT) strategy, policy, and funding coordination across the state, which includes development of and tracking progress toward the statewide health technology strategy, the Colorado Health IT Roadmap[26]. OeHI is advised by the eHealth Commission[27], which includes private and public sector representation from across the state.

OeHI focuses efforts and funding toward closing the gaps in health care for patients and providers. OeHI's unique position of working across state agencies and communities enables ideation, development, and execution of novel innovations to support better constituent experience, improved cost savings to the state and to Coloradans, and streamlined public and private efforts in the health care industry. OeHI is not permitted to own technology, which further incentivizes the team to identify partners to lead and manage shared solutions. Therefore, OeHI's ongoing General Fund is critical to ensure new and pivotal innovations for state agencies, health providers, and community partners.

Examples of OeHI-funded work include:

- Partnering with the state health information exchange (Contexture) and OIT to develop, pilot, and now expand the Identity Cross-Resolution Service (IDXR) across eight state source systems to link individual records without incurring additional tech debt. This service is being scoped as an offering to state agencies for next state fiscal year.
- Partnering with the Colorado State Library to fund 17 rural libraries (representing 24 different branches) in 2024 to purchase equipment that patrons can use for telehealth and other virtual services. These libraries span the entire state, from Dolores to Julesburg, in an effort to leverage existing infrastructure to increase telehealth access

[26] oehi.colorado.gov/colorado-health-it-roadmap
[27] oehi.colorado.gov/ehealth-commission/our-members

for rural communities. For more information on the project, visit the Connect to Health @Your Library website[28].

- Partnering with CDPHE and Visible Network Labs to develop the Colorado Cancer Survivorship Community Resource Referral Network. This work aimed to visualize cancer center-community resource connections, explore collaboration, identify growth opportunities, and highlight referral impacts for stakeholders. The resulting deliverables identified actionable opportunities to enhance access to resources for underserved populations and address related disparities in care across Colorado.

All OeHI Capital Construction requests begin as a pilot program funded from OeHI operations General Fund support. This enables the team and our partners to innovate and quickly determine whether the pilot or proof of concept is worthwhile for additional state support (whether from another state agency budget, an external funding source partner, or from a Capital request). If the project is not deemed to show adequate ROI or value to the state, we do not continue funding.

OeHI, with support of the Governor and Lieutenant Governor's Office, HCPF, and BHA, have received approval for two significant Capital IT requests that are currently underway. The Rural Connectivity Program focuses efforts and funding toward reducing the digital divide that exists between urban and rural health care providers and has enabled 100% of the identified Critical Access Hospitals and Rural Health Centers to connect to the state health information exchange infrastructure. Because of this work, Coloradans who become ill or injured in one part of the state can receive continuous care, and avoid duplicate and expensive diagnostic testing, when they return to their primary care provider at home. The Colorado Social Health Information Exchange (CoSHIE) is a network to securely share physical, behavioral, and social health information between providers involved in whole-person care. This initiative builds on already existing technology and processes to better provide the right health information to the right provider, at the right time. This will improve the significant administrative burden contributing to health care workforce burnout, as well as save Coloradans time, money, and trauma in repeatedly sharing their social health needs.

A 20% General Fund reduction would reduce OeHI's capacity to make meaningful and sustainable infrastructure investment. Most OeHI health IT projects leverage enhanced Federal funding for Medicaid IT systems at a 90% Federal Financial Participation (FFP) rate. For every $1 reduction in OeHI GF, $9 of Federal financing would be unavailable for innovation efforts in support of the Colorado Health IT Roadmap. With OeHI's particular focus on supporting innovations in underserved communities and with at least one, and often multiple, partners, this would disproportionately slow innovation in communities that need and benefit from it most.

Losing 20% General Fund would impact operations in the following ways:

- Reducing or eliminating ongoing support and expansion of the Rural Connectivity Program to equitably support modern technology, including critical cybersecurity

[28] telehealth.cvlsites.org/

funding, for rural health care facilities. With health care being the top industry at risk for cyberattacks, this funding and partnership with small rural facilities is more critical than ever.
    - To stand up this program, OeHI received $6,570,804 in General Fund from two concurrent Capital IT requests, in FY 2021-22 and FY 2022-23. We calculated these requests at a variable match rate, as some costs were not anticipated to be covered by federal fund match, leading to an anticipated $10,905,203 in federal funds. As it has been in the implementation phase, we received 90% federal fund match rate for the majority of our funds spent to date, resulting in $13,540,612 matched to date.
    - Starting in FY 2025-26, this initiative will move into the Maintenance and Operations phase, resulting in a 75% federal fund match rate ongoing. OeHI and HCPF have not submitted a budget request for this initiative at this time, and plan to utilize approximately $1,600,000 of OeHI's appropriated General Fund as the state share for the matching federal funds as we determine the appropriate level of funding needed for sustainability. Due to this higher investment from OeHI General Fund to continue this work, a 20% reduction would reduce the support for this program by minimizing ongoing development and instead maintaining the Rural Connectivity Program as it currently stands. This would maintain the technology gap of the remaining 40 rural providers.
- Slower statewide expansion of the CoSHIE regional hubs, as this funding would not be available to invest in and expand upon community infrastructure. This could result in inequitable and disparate access to the CoSHIE ecosystem, enabling some communities to better support their most vulnerable populations than others.

The 20% would equate to a $750,000 General Fund reduction and could result in leaving up to the 90% federal match for those funds, or $6,750,000 on the table.

44. [Sen. Bridges] Please provide a description of the County Incentive Program. What is the program incentivizing? Are these activities that counties would not engage in otherwise?

RESPONSE

The County Incentives Program is a critical component of HCPF's county oversight process. This program is part of a "carrot" (County Incentives Program) and "stick" (Regulatory Oversight) approach to ensuring counties prioritize performance that directly impacts members and prevents further risk for the state. The effectiveness of this "carrot" and "stick" approach is demonstrated by actual county performance amongst the different programs they administer. This is on pages 35-38 of the SB 22-235 Year 1 Report[29], which

[29] drive.google.com/ ile/d/1RI-L9vIjZIGdIF5WjwaFYhz7otJgPx3z/view?usp=drive_link

found better county performance for HCPF's programs than the other programs reviewed. Additionally, the previous workload study in 2017 found that the County Incentives Program drove significant behavior change in counties, to the point that the report recommended that HCPF continue to use performance incentives to drive further improvements (see pages 24 and 148 of the 2017 Workload Study[30], which was mandated by SB 16-190). Other county-administered states also use performance incentives programs to spur efficiencies and improvements (Maryland, for example, see page 133 of the 2017 Workload Study).

Currently, HCPF's County Incentives Program incentivizes:

- Timeliness of New Applications and Renewals and Reduced Backlogs, ensuring applicants and members receive benefits as expeditiously as possible.
- Accuracy of Determinations, so members get access to the right benefit package and the risk of federal disallowance from error rates is reduced.
- Average Speed to Answer of member calls, so that wait times at county call centers is reduced, ensuring access to eligibility services.

More information about the specific County Incentives Program performance standards is in HCPF Operational Memo 24-065[31] (Timeliness and Accuracy) and HCPF Operational Memo 24-064[32] (Customer Service – County Speed to Answer Targets[33] are also available). A copy of the program contract[34] is also available.

Without this appropriation, HCPF believes there would be a significant impact on applicants and members navigating the county administered system. Elimination of this program would eliminate the performance standards HCPF has established for counties; these performance standards directly impact how quickly and accurately members can access the county system. Prior to the implementation of the Accuracy and Average Speed to Answer standards, counties did not prioritize the accuracy of Medicaid determinations and county call center wait times were extremely high, with some hold times in excess of an hour and a half. Additional information on member impacts is in question 45.

Finally, the County Incentives Program was not included as part of the SB 22-235 analysis because that analysis focused the "core allocation" of what HCPF provides to counties. That report did not review any of the special financing mechanisms HCPF has for counties, such as the County Incentives Program or PHE county administration funding. Thus, there should be no inference made as to the effectiveness of the County Incentives Program because it was not included in the SB 22-235 analysis.

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[30] hcpf.colorado.gov/sites/hcpf/files/CDHS_HCPF_Final_Report.pdf

[31] hcpf.colorado.gov/sites/hcpf/files/HCPF%20OM%2024-065%20Implementation%20of%20the%20FY%202024-25%20Accuracy%20and%20Performance%20Compliance%20Incentives.pdf

[32] hcpf.colorado.gov/sites/hcpf/files/HCPF%20OM%2024-064%20Implementation%20of%20the%20FY%202024-25%20County%20Incentives%20Program%20Customer%20Service%20Incentive%20%281%29.pdf

[33] hcpf.colorado.gov/sites/hcpf/files/DRAFT-COMPELTE%20-%20%20ASA%20Targets%20for%20Tier%201%20FY24-25.pdf

[34] hcpf.colorado.gov/sites/hcpf/files/FY2023-24%20County%20Incentives%20Program%20%2812.2.2023%29.pdf

Note: The SB 22-235 Report is the overall outcome of the analysis; the SB 22-235 Year 1 Recommendations, developed from the report, were submitted to the JBC on Nov. 1, 2023.

45. [Sen. Amabile] What would be the impact of eliminating the appropriation for the County Incentive Program for county administration of medical assistance programs? How would this impact those seeking services?

RESPONSE

The impact of eliminating the County Incentives Program appropriation would likely be devastating, with a nearly complete unraveling of the performance standards HCPF has set for counties that directly, and significantly, impact members. Additionally, the risk of federal disallowances to the state, resulting from higher error rates and customer service barriers, would likely dramatically increase. As a reminder, any federal sanctions for inaccurate eligibility determinations by counties (or other sanctions resulting from how counties administer HCPF's programs) must be absorbed by the state General Fund; HCPF is statutorily restricted from passing federal sanctions onto counties.

Negative Impacts to Applicants and Members

Eliminating the County Incentives Program appropriation would likely result in significantly increased barriers for applicants and members in accessing county services, as the standards HCPF holds counties to would be eliminated. This would likely:

- Increase the amount of time it takes for counties to process applications and renewals, delaying access to services.
- Increase the likelihood that county backlogs would increase, reversing the recent trends that show backlog reductions and an increase in members having timely determinations.
- Increase the likelihood that members will not receive the correct benefit package, as error rate monitoring of counties would be eliminated.
- Dramatically increase county call center wait times; without the specific performance standards for average speed to answer, member wait times may return to the 1-2 hours that were previously the case.

While the County Incentives Program funding is specifically for counties, the funding has a dramatic impact on how counties provide services to applicants and members. Eliminating this appropriation would be devastating to applicants and members seeking timely, accurate determinations and support through county call centers.

Elimination of a critical piece of HCPF's county oversight

HCPF's processes for holding counties accountable are based on the ability to incentivize higher performance where federal standards are ambiguous and the authority to put counties on corrective action where the federal standards are clear. For instance, the federal

government dictates to state Medicaid programs that call center wait times for eligibility determinations cannot be so long as to create barriers to accessing eligibility determinations. However, the federal government does not dictate a specific wait time performance metric. Thus, HCPF has had to translate federal guidance into an actionable performance standard that incentivizes counties to reduce call wait times, with an ultimate goal of a five (5) minute or less wait time. This goal is also reflected in the SB 22-235 Funding Model, Call Center adjustment that provides counties with additional funding to meet this standard (however, the elimination of the County Incentives appropriation would eliminate the ability for HCPF to hold counties to this standard).

Beyond member experience through customer service standards, the County Incentives Program plays a critical role in controlling county error rates. The federal standard established for all public and medical assistance programs payment error rate is 3% or less. Any error rate above that amount requires the state to pay back the federal government based on an extrapolated amount across all enrollees. This means that potentially small errors found by the federal government can be extrapolated into large disallowance amounts. Disallowances are only paid to the federal government, but can be calculated by others, including the Office of State Auditor (OSA). This comparable 2019 OSA audit[35] is different from the federal audit that determines actual disallowances, **but found a likely cost for the state from county eligibility errors (which then resulted in inappropriate billing for services from ineligible individuals) nearing $283 million**. That amount determined by the audit was based on the below; this is also available in the 2019 OSA Audit Summary[36]:

- Auditors found issues with 8% of case files from counties missing documentation necessary to support the eligibility determination.
- Auditors also found data entry mistakes in 16% of cases; that is, the data in CBMS system did not match supporting documentation due to county caseworker data input error.

Because of these OSA and other audit findings, HCPF implemented provisions in the County Incentives Program to hold counties accountable to error rates. For HCPF's most recent federal review, the state was able to achieve the 3% error rate target, likely because of the accuracy provisions of the County Incentives Program.

Eliminating the County Incentives appropriation would mean HCPF would lose authority to hold counties accountable where federal guidance is ambiguous. Additionally, this would shift HCPF's county oversight to a more punitive approach where corrective action is the only process HCPF can utilize to hold counties to requirements where the federal standards are clear. The risk to the state General Fund from federal disallowances would also increase, as the County Incentives appropriation of $8 million acts as a deterrence against these disallowances. It is in the state's best interest to continue to fund this program as a limitation on risk, rather than risk audit disallowances which can total hundreds of millions of dollars.

[35] hcpf.colorado.gov/sites/hcpf/files/2019%20OSA%20Report.pdf
[36] hcpf.colorado.gov/sites/hcpf/files/2019%20OSA%20Report%20Summary.docx

46. **[Sen. Amabile] How has the Medicaid unwind affected expenditures for the County Incentive Program?**

RESPONSE

The Medicaid Public Health Emergency (PHE) Unwind has not affected the expenditures for the County Incentives Program; the program is a fixed allocation that incentivizes higher performance amongst counties. This funding is provided to counties annually based on their performance against state and federal performance standards.

ELIGIBILITY, R7 COUNTY ADMINISTRATION AND CBMS

47. **[Sen. Bridges] Please discuss the benefits and drawbacks of the state-supervised, county-administered model for the administration of medical assistance programs. What does it look like fiscally and for enrollment if we manage eligibility determinations at the state level instead of the counties? What efforts has the Department made to standardize this process across counties?**

RESPONSE

On Nov. 1, 2024, HCPF submitted the FY 2025-26 R-7, "County Administration and CBMS Enhancements," to support and further invest in our existing county administered structure. A detailed fact sheet[37] is available on the R-7 request and includes information on the companion R-1 request from the Colorado Department of Human Services. Any significant changes to this structure would involve detailed cost/benefit analysis and thorough stakeholder engagement to ensure it is the right path for Colorado.

Our state supervised, county administered structure has several benefits. Staff at the counties are part of their communities, know the individuals they are serving and can connect those individuals and families to a wider array of services for which they qualify addressing broader needs than medical assistance. Some of those services may be other state programs, like SNAP, while others may be specific community level or county funded supports that are not state financed benefits. According to HCPF's County Customer Service Survey data, which collects thousands of responses annually, counties receive a statewide ranking of 4 out of 5 Stars (5 being the highest ranking). This demonstrates that the vast majority of Coloradans seeking eligibility services from counties are more than satisfied with their experiences.

Some of the drawbacks of our model were identified in the SB 22-235 report, which compared us to other states to suggest best practices. That analysis was not specific to Medical Assistance programs but more inclusive of all state benefits. We are working to address the

[37] hcpf.colorado.gov/sites/hcpf/files/CHDS%20R-01_HCPF%20R-07%20Fact%20Sheet.pdf

policy and process improvement findings in the SB 22-235 reports (published in November 2023), such as improving consistency of administration and member experiences across counties. The Joint Agency Interoperability (JAI) project will create a single workflow management, document management and repository to address a drawback of the current system where sharing of documents across county systems is challenging when members move to a different county.

At this time, HCPF does not have adequate information to determine the actual cost or impact on enrollment of transitioning from a county-administered enrollment system to a state-administered one. There are multiple facets to consider beyond the actual processing staff that must be accounted for in this type of transition. However, HCPF has utilized some existing data points to provide some context for what a transition to a state-administered system would mean.

How the System is Currently Structured

In our current county-administered system, county departments of human/social services are primarily responsible for determining eligibility for Medicaid. According to federal regulations, only a governmental, merit-based employee can determine eligibility for our programs. This limits who can determine eligibility, mainly to state, local, special district or quasi-governmental agencies. Prior to HCPF's creation in 1992, the state elected to delegate eligibility activities to each county; however, this is not a federal mandate. The federal government allows states to determine what structure they choose, whether state or locally administered. In addition to Medicaid, counties are also responsible for determining eligibility for other public assistance programs, mainly those supervised by the Colorado Department of Human Services (CDHS). As a result, HCPF and CDHS share the costs of running eligibility programs that are county-administered.

Staffing

According to HCPF's user data from the Colorado Benefits Management System (CBMS), there are approximately 2,000 users at any given time that may process a Medicaid application or renewal. Simultaneously, according to administrative cost allocation methodologies, HCPF typically pays around 40% of all county costs, with CDHS paying the other 60%. If we applied this percentage to the overall workforce, approximately 800 FTE would be necessary to process eligibility in a state-administered system. Currently, as found in the SB 22-235 Year 1 Final Report, counties pay a range of salaries to their eligibility staff throughout the state. These salaries range from approximately $28,000 to $55,000; in a state-administered system, those salaries would be higher than they are locally. Included in the R-7 request is a salary analysis for eligibility processing staff. The analysis does not account for call center or other administrative functions.

Beyond the eligibility processing workforce, HCPF would need to operationalize other functions that are currently county-administered but are related to eligibility processing. These include administrative support, call center agents, program integrity staff, document management staff, outreach/community liaison staff, and other types of functions currently performed by counties. Without specific information on how counties currently staff these

functions, HCPF estimates approximately 200 additional FTE would be necessary in these supportive functions.

If 1,000 FTE were necessary for a state-administered system, then the following considerations would need to be accounted for:

- These 1,000 FTE would then be subject to COWINS requirements
- The 1,000 FTE would be subject to equal pay for equal work, meaning HCPF would have standardize pay scales
- Certain indirect costs for these FTE would be absorbed by HCPF, where currently those costs may be borne by the counties and federal government.

General Fund Impact

Statutorily, counties are required to bear a portion of their costs related to locally administering HCPF's programs; this can range up to 20% of the total costs. In the FY 2023-24 funding allocation to counties, HCPF estimated the county's portion of costs to be $15,753,837. Moving to a state-administered system would require the state to absorb all the costs currently paid by the counties. Assuming that there would be additional efficiencies gained by no longer delegating responsibilities to the 64 counties, HCPF would still bear a large portion of those costs. Using the same administrative cost allocation percentages, HCPF would need an additional $6.3 million (40% of $15 million) in General Fund only. Because the state does not have previous experience with a state-administered system, HCPF believes that $6.3 million would be on the low end of what is necessary, as this doesn't account for other factors, like statewide locations.

Statewide Locations

The federal government requires Medicaid to be delivered through a system of local offices where administration is consistent and equitable, with mandatory standards set by the single state Medicaid agency (HCPF). Federal law does not require this system of local offices to be in each county; the state has elected to structure it in this fashion. As HCPF is based solely in the Denver Metro Area, with limited remote workers across the state, moving to a state-administered system would require HCPF to procure a series of office locations throughout the state to ensure every Coloradan has the appropriate access to eligibility services. HCPF would then need to hire local staff to support this system of local offices throughout the state – likely from the counties. Without further analysis, HCPF does not have sufficient information to determine the costs related to these local offices, though the costs would likely total millions of dollars in new funding.

Additional Considerations

How other States do this Work

Medicaid is primarily a state-administered program; around 40 states are state-administered, or around 80% of states. The remaining ten or so states are county-administered, though there is not a specific federal Medicaid definition for that designation. Within the range of

county-administered states, none look quite the same. There has been a recent movement in some county-administered states to restructure their systems to be more cost efficient and effective and to gain additional economies of scale. In 2014, Wisconsin moved from purely county-administered to *consortiums*; in this model, Wisconsin grouped its counties together rather than delegating to each county. Similarly, in 2020, North Dakota moved to create *human services zones*, where groups of counties were joined together, both to reduce the administrative burden on small counties, and to improve outcomes and gain efficiencies. It is important to recognize that this is not a binary choice between county and state-administered, but that other states have left some element of local administration in place while restructuring their systems to improve service delivery and gain cost efficiency.

Shifting of County Costs from HCPF to Only CDHS

Any movement of Medicaid towards a state-administered system would likely result in a shifting of county costs from HCPF to CDHS. This could be detrimental to the state General Fund, because currently, HCPF draws down enhanced federal matching funds that support county administration. If HCPF's enhanced federal match were no longer available to counties, they would shift those costs to CDHS, where a lower federal match rate is required.

One Stop Shop for Coloradans

One of the qualities of the county-administered system is that a Coloradan in need of benefits can go to their county and get access to Medicaid, food assistance and cash assistance, child care and other services all in one stop. That is one of the strengths of Colorado's local delivery system. Moving to a state-administered system would result in a bifurcation of the system that would mean a Coloradan would need to go to their local HCPF office to receive Medicaid, and then their county to access other benefits managed by the counties. This may produce a more disparate experience for low-income families and individuals trying to quickly access the benefits they may be entitled for and should be a factor in any decision-making process.

Standardization Across Counties

According to federal regulation (42 CFR Part 431.50(b)), the state has a clear directive that Medicaid must "be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the state." With our county-administered system, there are wide variations in process between different counties, county sizes and geographic locations. This variance means that Colorado may actually not be in compliance with that federal regulation, because many processes are not standardized or mandatory, creating inequities across the state. This was further supported by the findings of the SB 22-235 Year 1 Final Report, where one of the Transformative Recommendations was the establishment by the state of business process standards where counties must adopt standardized processes to create efficiencies, reduce costs and better serve applicants and members.

To that end, HCPF included in the R-07 request 1.0 FTE that will help develop those business process standards and hold counties accountable to those, though standardization may take years, with many unknowns. Additionally, through HCPF's 2025

County Administration rulemaking, HCPF will be operationalizing a new regulation which mandates counties comply with those business process standards. However, failure to approve the FTE requested would likely delay or completely eliminate HCPF's ability to implement these business process standards, leading to continued variation in processes, driving costs and inequities.

48. **[Sen. Kirkmeyer] Please provide a table or graphic with the income limits for the populations on Medicaid and CHP+. Please convert these income limits to approximate annual incomes (after standard income disregards) to explain who is covered. In addition, please indicate the income thresholds to qualify for federal tax credits to help purchase private insurance and the approximate values of those tax credits.**

RESPONSE

The following are the tables with the income limits for the populations on Medicaid and CHP+ based on annual income limits. Standard income disregards are applied to applicants'/members' income and then compared to these income limits.

Medicaid Annual Maximum Income Guidelines, Effective April 1, 2024

Chart 1 is the annual income limit for Medicaid programs. Here is a link to the chart broken down by monthly amounts:

hcpf.colorado.gov/sites/hcpf/files/April%202024%20Medicaid%20Income%20Chart_1.pdf

Chart 1: Annual Income Limits for Medicaid Programs

Family Size	Parents & Caretaker Relatives 68% Poverty Level	Adults (Ages 19-65) 133% Poverty Level	Children (Ages 0-18) 142% Poverty Level	Pregnant Women 195% Poverty Level
1	$10,240.80	$20,029.80	$21,385.20	$29,367.00
2	$13,899.20	$27,185.20	$29,024.80	$39,858.00
3	$17,557.60	$34,340.60	$36,664.40	$50,349.00
4	$21,216.00	$41,496.00	$44,304.00	$60,840.00

Child Health Plan *Plus* (CHP+) Annual Maximum Income Guidelines, Effective April 1, 2024

Chart 2 is the annual income limit for CHP+ children and pregnant women. Here is a link to the chart broken down by monthly amounts:

hcpf.colorado.gov/sites/hcpf/files/April%202024%20CHP%2B%20Income%20Chart_1.pdf

Chart 2: Annual Income for CHP+ and Pregnant Women

Family Size	Poverty Level Income Limit 260%
1	$39,156
2	$53,144
3	$67,132
4	$81,120

Regarding the income thresholds to qualify for federal tax credits, there is not one single chart for the approximate value of tax credits. The reason for this is that the tax credits are dependent on the cost of the second lowest cost silver plan in an individual's rate area (so this changes frequently) and it is a complicated formula. Connect for Health Colorado generally encourages people to apply and see what financial assistance they are eligible for. Chart 3 below is one example for Denver County ONLY and includes the current tax credits and the expected decrease in tax credits at the end of 2025. These tax credits vary significantly by age and area in which they live in (rate area).

Chart 3: Denver County tax credit values

Approximate Value of APTC for a single person in Denver County, based on age and Income, with enhanced PTC

FPL:		150%	200%	250%	300%	350%	400%	450%
Montly Income:		$ 1,883	$ 2,510	$ 3,138	$ 3,765	$ 4,393	$ 5,020	$ 5,648
Age	20	$ 332	$ 282	$ 206	$ 106	$ 13	$ -	$ -
	30	$ 388	$ 338	$ 263	$ 162	$ 70	$ -	$ -
	40	$ 437	$ 387	$ 312	$ 211	$ 119	$ 11	$ -
	50	$ 611	$ 561	$ 486	$ 385	$ 293	$ 184	$ 131
	60	$ 929	$ 878	$ 803	$ 703	$ 610	$ 502	$ 449

Approximate Value of APTC for a single person in Denver County, based on age and Income, after expiration of ePTC at the end of 2025

FPL:		150%	200%	250%	300%	350%	400%	450%
Montly Income:		$ 1,883	$ 2,510	$ 3,138	$ 3,765	$ 4,393	$ 5,020	$ 5,648
Age	20	$ 260	$ 180	$ 89	$ -	$ -	$ -	$ -
	30	$ 316	$ 236	$ 146	$ 45	$ -	$ -	$ -
	40	$ 365	$ 285	$ 195	$ 94	$ 37	$ -	$ -
	50	$ 539	$ 459	$ 369	$ 268	$ 210	$ 153	$ -
	60	$ 856	$ 777	$ 686	$ 585	$ 528	$ 471	$ -

There is no upper cap to income eligibility for tax credits. All are eligible for them if the cost of the second lowest cost silver plan exceeds 8.5% of their income. The value of tax credits equals the difference between the cost of the second lowest cost silver plan and the

"applicable percentage" of their income, which varies based on income (the applicable percentage is 0% if they are below 150% FPL, all the way up to 8.5% at 400% FPL and above). In addition, individuals may also be eligible to receive cost-sharing reductions. Below is a link to Connect for Health's site that guides individuals.

connectforhealthco.com/financial-help/get-financial-help/

49. **[Sen. Kirkmeyer] The department's budget request R7 would invest additional funding to support counties to do enrollment / reenrollment work in Medicaid. This seems like an essential investment but only a partial strategy to address the current disenrollment / eligible-but-not-enrolled crisis Colorado is facing in the wake of COVID and the Public Health Emergency unwind. It seems logical to me that allowing community-based health care organizations (e.g. - hospitals, FQHCs, CMHCs, safety net clinics) to relieve pressure from county infrastructure by acting as partners in the enrollment process should also be prioritized. It is my understanding that in the past, Colorado has employed a "no wrong door" approach to Medicaid enrollment, allowing providers to play an active role in supporting Medicaid member enrollment. Going back to 2010 please provide a brief overview of Colorado's policy and approach to community-based eligibility and enrollment activities. Please address the current role community-based health care organizations are playing in Medicaid eligibility and enrollment today, as well as your understanding of what is permissible under federal law. Finally, please address your rationale for the current policy and your response to the suggestion that HCPF do more to partner with community-based organizations to support Medicaid eligibility and enrollment activities in the future.**

RESPONSE

1. **Going back to 2010 please provide a brief overview of Colorado's policy and approach to community-based eligibility and enrollment activities.**

   The Centers for Medicare and Medicaid Services (CMS) has had a long-standing requirement for states to provide opportunities for all individuals to receive assistance and/or apply for Medical Assistance at locations other than county human services. A State Medicaid Director Letter (SMDL[38]) from Jan. 18, 2001, promoted that families "are much more likely to enroll children in Medicaid if they could do so in convenient locations within the community, such as doctor's office or clinic, or a school or day care center." As such, HCPF has a long-standing approach to partner with community organizations to provide assistance to families to apply for and enroll in Medical Assistance programs.

[38] www.medicaid.gov/Federal-Policy-guidance/downloads/smd011801b.pdf

CRS 25.5-4-106(5) allows for Medical Assistance eligibility and enrollment help to be delivered by the county departments of human services or any other public or private entities that meet federal requirements. Medical Assistance (MA) sites were established as part of this regulation to provide support to individuals and families. In 2009, HCPF received a grant from the federal Health Resources & Services Administration (HRSA) that provided an opportunity from 2009 through 2013 for local organizations to apply for funding to outreach their local populations for eligibility and enrollment assistance. The outreach and community partnerships developed from the HRSA grant created a solid base to draw from during the roll out of the Medicaid expansion population.

This strong group of community partners helped HCPF with grassroots communications to get the word out about the new coverage levels and established a strong foundation for us for working with community partners going forward. We provide additional details of our current partnerships in our response to part two of this question below.

2. **Please address the current role community-based health care organizations are playing in Medicaid eligibility and enrollment today, as well as your understanding of what is permissible under federal law.**

Federal law at 42 C.F.R. § 431.10(C)(2) stipulates, "Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis." CMS has instructed HCPF that only merit-based, government employees may "use discretion in decision making when evaluating eligibility," meaning only employees of a governmental entity may fully determine eligibility. HCPF is also required by CMS to conduct oversight of all entities performing any type of formal eligibility determination or eligibility assistance, particularly any site that accesses in any way the Colorado Benefits Management System (CBMS), the state's eligibility and enrollment system.

HCPF has formal agreements (e.g., contracts, MOUs, intergovernmental agreements) with partner sites to ensure that they can meet all requirements to be compliant and successful as a partner site. For example, they must agree and be able to:

- Follow all current and changing federal and state rules, regulations, policy, and guidance.
- Receive initial training and continue ongoing training as needed for all programs, policies, and systems.
- Provide adequate staff to meet specific customer service performance levels such as average speed-to-answer for phone calls and application processing times.
- Meet federal and state security, privacy, and confidentiality requirements.
- Track and report staff time spent on eligibility for medical assistance programs to ensure correct and timely federal match rates, which HCPF uses to support their

eligibility-focused work (Medical Assistance and Eligibility Application Partner sites only)
- Accept all applicants who choose to apply through their sites.
- Accommodate individuals with special needs such as physical and developmental disabilities and low English literacy (LEP).

PEAK. Additionally, anyone can use the **PEAK Application** to enroll in Medicaid and CHP+, and this is the fastest way to determine eligibility for new members. Those who apply with all their income and other verification information can also get a real-time eligibility (RTE) determination. In fact, **between 35 and 50%** (depending on whether they are renewing or doing a new application) of all PEAK applicants receive an RTE. Further, nearly 336,000 households' renewals were submitted through PEAK so far this calendar year. We also know that 70% of all PEAK users access their accounts via their smartphones. Only five other states have an integrated self-service portal for Medicaid, CHIP, SNAP, TANF, and Adult Financial programs. The PEAK product has over 75 items for improving user experience under research. However, PEAK allows applicants and members to apply for benefits, check eligibility information, complete renewals, process applications, update case information, and upload documents. Any organization or agency can assist individuals in using the PEAK application for new enrollments, and many do. Note that there are some instances where PEAK is not the optimal option for applying for coverage – for example, using PEAK to enroll large households can be somewhat cumbersome, or for long-term care applications.

Notably, there also are other types of assistance, such as navigators and financial counselors, used by many organizations and agencies to provide guidance to individuals and families seeking enrollment in multiple state programs. While we like to know about them and often do provide training or assistance in understanding programs and policies, HCPF does not formally oversee these organizations or agencies.

The multiple, formal eligibility and enrollment support options HCPF offers fall across a variety of partners ranging from counties to hospitals, to clinics, and large provider groups, to community-based organizations. These options are detailed below, with indications of which are suitable for different types of entities based on federal rules and HCPF capacity for required oversight.

Counties. County departments of human/social services are primarily responsible for determining eligibility for Medicaid and CHP+, as well as other benefit programs like SNAP, Adult Financial, and Colorado Works. Counties carry caseloads, process renewals and reported changes, and have full access to CBMS. **They are staffed with merit-based, governmental employees and can therefore use discretion in decision making when evaluating eligibility; this is a federal requirement.** They also assist individuals applying for long-term care or disability coverage, which are the most complex and time-consuming medical assistance eligibility determinations.

Medical Assistance (MA) Sites. MA sites can determine eligibility for Medicaid and CHP+, but not other benefit programs. MA sites carry caseloads, process renewals and reported changes, and only work on medical assistance screens in CBMS. *They are staffed with merit-based, governmental employees and can therefore use discretion in decision making when evaluating eligibility*. They also can assist individuals applying for long-term care or disability coverage, which are the most complex and time-consuming medical assistance eligibility determinations.

- Currently HCPF pays or passes through a federal match to these sites for their work; thus, they must participate in the Random Moment Time Study (RMTS) for cost allocation.
- MA site staff can use CBMS to enter applicant information and determine eligibility.
- HCPF manages MA site contracts in the Contracts & Site Relations Section, which holds bi-weekly meetings with them to ensure program and contract compliance, discuss issues and trends, and identify opportunities for improvements.

Eligibility Application Partner (EAP) Sites. EAP sites can assist individuals applying for Medicaid and CHP+ at initial application only, but not other benefit programs. EAP sites do not carry caseloads and do not work cases in "ongoing" status or renewals. They only work in medical assistance screens in CBMS. They are **not** staffed with merit-based, governmental employees and therefore **cannot use discretion in decision making** when evaluating eligibility.

- Some sites are funded, some are non-funded, due partially to limited available funding. Some organizations and agencies choose to absorb the costs of operating as an EAP site because of the benefits to them and to the individuals seeking assistance through them.
- Once an initial determination is made, the case is transferred to the applicant's county of residence for ongoing maintenance or to an MA site that carries a caseload (determined by the system).
- HCPF manages EAP site contracts in the Contracts & Site Relations Section, which holds bi-weekly meetings with them to ensure program and contract compliance, discuss issues and trends, and identify opportunities for improvements.

Presumptive Eligibility (PE) Sites. PE sites can give some individuals immediate, temporary Medicaid and CHP+ medical coverage. PE covers children under age 19 and pregnant people, individuals eligible for the Breast and Cervical Cancer Program (BCCP), and individuals eligible for the limited Family Planning Limited Benefit. PE sites assist members in completing the application. PE sites can access only the PE screens in CBMS. Completed applications are forwarded to the applicant's county of residence to make a full eligibility determination. PE sites may, but are not required, to use PEAK to enter the application side by side with an applicant to get an RTE determination. They currently:

- Must be certified every year, which includes an audit of cases completed in CBMS for accuracy
- Must receive ongoing training, including when program or policy changes are implemented
- Do not carry a caseload
- Do not assist with long-term care or disability applications
- Receive no funding from HCPF

Certified Application Assistance (CAAS) Sites. CAAS sites are community-based or non-profit organizations that agree to be listed on the HCPF Mapping Tool as a community resource, authorized by HCPF to assist individuals in applying for Medicaid or CHP+. This includes assistance gathering all the appropriate required verifications and completing applications. CAAS site staff do not have access to CBMS; completed applications are forwarded to the applicant's county of residence to process and make an eligibility determination. CAAS sites may, but are not required, to use PEAK to enter the application side by side with an applicant to get an RTE determination. CAAS currently:

- Must be recertified every two years, including taking a refresher training through HCPF's website and verifying their site information is correct in the online Mapping Tool.
- Receive no funding from HCPF and do not have formal contracts with HCPF.
- Do not assist with long-term care or disability applications.

The table below provides a quick snapshot of the different types of partner sites.

Types of HCPF Eligibility and Enrollment Partner Sites

Type of Site	Discretion of Eligibility	Merit-based, Government Employee	Ongoing Caseload	Access to CBMS	MA only	Current number of sites
County*	Yes	Yes	Yes	Full Access	No	59
Medical Assistance Site (MA)	Yes	Yes	Yes	Limited to Medical Assistance	Yes	3
Eligibility Application Partner Site (EAP)	No	No	No	Limited to Medical Assistance	Yes	8
Presumptive Eligibility Site (PE)	No	No	No	Limited to PE screens	Yes	34
Certified Application Assistance Site (CAAS)	No	No	No	No	Yes	143

As of Dec. 23, 2024, HCPF has formal relationships with the following organizations to support eligibility and enrollment.

Medical Assistance Sites as of December 2024

Site Name	Date Launched
Denver Health MA Site	2006
Colorado Medical Assistance Partner (CMAP)	2015
Connect for Health Colorado (COHBE)	2018

The CMAP is a unique partner in that they provide multiple services, in addition to application assistance. The CMAP contract is currently held by Denver Health, and includes:

- A call center to assist individuals with applications, including completing an application over the phone and taking a telephonic signature.
- Support and eligibility assistance for Colorado Department of Corrections for individuals preparing to leave incarceration.
- Support for the Medicaid Buy-In Program.
- CHP+ payment processing.
- A Liaison Line for EAP, CAAS, and PE sites, as well as certain providers who need assistance with eligibility and enrollment questions or issues.

Eligibility Application Partner Sites as of December 2024

Site Name	Date Launched
Colorado Access	2014
Denver Indian Health & Family Services	2011
Kemberton (Revecore)	2012
Northwest Colorado Visiting Nurses Association	2015
Pueblo StepUp (CHI)	2010
UCHealth/Parkview	2011
Express Eligibility Connections	2017
Hilltop Family Services	2015

Certified Application Assistance Sites as of December 2024

There are more than 140 Certified Application Assistance Sites across Colorado. Please see the appendix for the full list.

Presumptive Eligibility Sites as of December 2024

There are 30+ Presumptive Eligibility Sites in Colorado (see appendix). These sites can be located using the HCPF Eligibility Site Mapping Tool[39], which is available on the HCPF website and shared through many of our partners. This tool also allows applicants to find sites that specialize in different types of support, such as for Spanish-speakers, those seeking Long-Term Care application assistance, and those looking for help with multiple programs.

Again, it is important to note that any partner, regardless of their type or location, can currently use PEAK to support individuals in applying for assistance for Medicaid, CHP+, SNAP, TANF, and Adult Financial programs. This is the fastest way to help most individuals and families get coverage, and it requires little to no resource commitment on the part of partners. They simply need to have staff trained and ready to support individuals in using the application.

3. **Finally, please address your rationale for the current policy and your response to the suggestion that HCPF do more to partner with community-based organizations to support Medicaid eligibility and enrollment activities in the future.**

   Medicaid and CHP+ eligibility is complex. There are myriad federal and state rules and regulations that govern who is eligible, when they are eligible, how they must enroll, who can enroll them, how long they can stay enrolled, etc. We understand that complexity and our goal is to create an ecosystem of eligibility and enrollment sites that allows individuals and families to find information about and get enrolled in programs for which they are eligible as quickly and easily as possible through their preferred means – from self-service with PEAK all the way to sitting with a county eligibility worker to go step-by-step through the application.

   HCPF is continuing to build on the above approach to partnering with a variety of organizations and agencies to expand access to eligibility and enrollment supports for as many people as possible. We are approaching this in a thoughtful, deliberate way so we can ensure that our formal partners provide high quality, timely, accurate, and efficient assistance. We also must ensure we have adequate resources to meet our obligations to oversee the actions and activities of each of our partners, as we are held accountable to CMS for them. These obligations and associated resources are outlined in more detail below.

   - Thorough review of each site's ability to meet federal mandates every three years including:
     - Eligibility processing requirements and internal controls.

[39] apps.colorado.gov/apps/maps/hcpf.map

    - Administrative internal policies and procedures, such as confidentiality of member data.
    - Implementation of new rules, policies and Memos issued by HCPF.
    - Adherence to federal civil rights and accessibility expectations.
- Performance Metrics Monitoring
    - Accuracy of case completion.
    - Timeliness of case completion.
    - Backlogs of untimely determinations and renewals.
    - Overall level of customer service/satisfaction through call center monitoring and customer service surveys.

There is currently a team of four individuals who monitor the current sites for adherence to the federal standards. There are an additional two individuals who monitor sites for performance, and issue corrective actions when those performance expectations are not met. Additionally, there are two contract managers who support daily oversight of MA/EAP sites.

The first major update to our approach is the proposed 2025 Rule Revisions for County Administration of Medical Assistance fiscal and programmatic operations of the county departments of human/social services (counties). These rules set standards for fiscal and program compliance, customer service, non-discrimination and accessibility, and more. These critical changes are tied to HCPF's FY 2025-26 R-07 request, which includes $21 million in new funding for counties and are designed specifically to address member, community, and provider feedback. Guiding principles of our new county administration rules include:

- Meeting federal oversight and compliance standards
    - Addressing federal non-compliance.
    - Requiring all modalities of member engagement - phone, mail, and email.
    - Incorporating county requirements for the state escalation/complaint process into rule.
    - Clarifying language access provisions and no-cost language translation.
    - Incorporating personnel screening standards for county eligibility staff into rule.
    - Clarifying county training oversight, including standards for county trainers to have ongoing certification from HCPF.
    - Ensuring public posting of office hours and closures.
- Improving Member Experience

    - Setting county customer service standards, such as call wait times and application processing times.
    - Allowing members to receive unencrypted emails if they complete the appropriation documentation.
    - Facilitating greater collaboration between counties and hospitals, nursing facilities and case management agencies.
    - Appointing Customer Relations Coordinators in each county, so members have escalation contacts if they cannot navigate the standard county process.
    - Adding new compliance review types, including Performance, Training and Complaint Reviews, to improve member experience.
- Modernizing fiscal rules
    - Easing unnecessary burden on counties by eliminating duplicative or redundant requirements for fiscal compliance.
    - Adding federal and state language for allowability of costs.
    - Incorporating requirements for administrative federal match rates into rule and improving state compliance and oversight of federal match.
    - Adding a new, informal non-compliance notice to address issues prior to HCPF's formal county compliance process.
    - Engaging counties and any other interested parties in the Rulemaking Process through opportunities to review proposed language, formal written comment, and public comment at rulemaking hearings.

The second major effort we are undertaking is to work more deliberately with partners to ensure we are deploying the most appropriate and effective eligibility support options in the right places. We also want to align with the new county administrative rules to create an overall eligibility support continuum that ensures a "no wrong door" system for individuals and families to access assistance as easily as possible. With limited resources, it is important for us to focus on making our assistance network as effective and efficient as possible.

Collaborating with CHA, Hospitals and Other Large Provider Partners. As a start to this, we are pleased to share that we are collaborating with CHA, focused through UCHealth senior leaders to evaluate the most appropriate types of eligibility support sites across the entire UCHealth system, which includes hospitals throughout Colorado from large urban centers to smaller rural facilities. This collaboration benefits both HCPF, UCHealth and hospitals, and will help us advance and create as needed important standards, criteria, guidance, training, contractual mechanisms, and funding plans for working with a variety of partner sites. For example, we are exploring opening new assistance sites at both University Hospital and at Memorial Hospital, where UCHealth experiences their high volumes of uninsured patients. In collaboration with county leadership, we also are working through refinements that will further the placement of county staff at these locations to ensure the broadest system (CBMS) access for out-stationed county workers located on site with our largest provider partners who will be able to more efficiently meet the needs of new

applicants and members. While we move forward with more robust eligibility site options at these two locations, we also will explore what options would be most effective and viable at other UCHealth hospital locations and other providers, like PACE organizations, FQHCs and the like. We will assess each location for factors such as their volume of uninsured and Medicaid/CHP+ eligible patients, staffing capacity, where they can physically locate eligibility workers, their relationships with counties, and other community eligibility resources in proximity to them. Based on these factors and other criteria, together we will determine the appropriate level of partnership.

Another key aspect of our work with UCHealth includes consulting with their financial counselor teams, who often use the PEAK application to assist patients in determining their eligibility and completing enrollment in Medicaid/CHP+. They are working closely with our PEAK management team to give them quick feedback on what works well, what users like and use frequently, as well as what challenges they encounter when working with applicants in the PEAK app. This will give us timely input from "boots on the ground" users which will allow us to do trainings when we see training issues and develop plans for making improvements to the tool itself, both "quick fixes" when possible, as well as longer-term updates.

As we build out our collaboration, we simultaneously will be developing a contractual agreement that ensures HCPF has requisite oversight of all eligibility activities yet is flexible enough for HCPF, UCHealth and other providers to make updates and changes to site locations as needed. This includes how HCPF will support hospitals, UCHealth and other provider partners, while empowering and leveraging counties to align roles and responsibilities, funding structures, and compliance with federal and state rules and regulations.

The pilot HCPF is conducting with UCHealth will provide valuable insights for us as we also evaluate how we can more effectively work with other hospital partners. Similar, but more informal, structures were in place prior to COVID but were decommissioned or discontinued during COVID for a variety of reasons. On Jan. 15, 2025, HCPF will present a webinar of eligibility support options for members of the Colorado Hospital Association. This will include an overview of current types of partners, the federal and state requirements for each, and the funding mechanisms for each. It also will be an opportunity for HCPF to hear directly from hospital leaders about the specific issues and challenges they face and for us to collectively brainstorm short and longer-term solutions. This includes a focus on using the PEAK application when and where possible, leveraging current Presumptive Eligibility (PE) for children and pregnant persons, preparing for the launch of PE for all MAGI categories on Jan. 1, 2026, and ensuring enrollment in Covering All Coloradans for any eligible children and pregnant persons as of Jan. 1, 2025.

In addition to working with hospital partners, HCPF will also refocus on how we partner with federally qualified health centers, rural health clinics, community mental health centers, and other community-based organizations, particularly through the option for them to be Certified Application Assistance Sites (CAAS). We are exploring how we can both establish adequate oversight of these sites to ensure they are

operating with high quality and adequately trained staff, while also allowing them to have as much flexibility as possible to serve their communities as effectively as possible.

50. [Sen. Kirkmeyer] Given the recent growth of the Department, what is the Department's reasoning for requesting 15.7 FTE (representing 17 new positions) in FY 2025-26?

RESPONSE

The staff requested in the FY 2025-26 R-7, "County Administration and CBMS Enhancements," are for dedicated resources to address member escalations, the components of the SB 22-235 study, and to implement more projects in CBMS through pool hours and other innovations. These are detailed in the response to question 51. The recent increases in FTE at HCPF were not specific to these initiatives. The increases were primarily driven by the administrative costs to implement specific projects and policies, such as HB 22-1289, "Health Benefits For Colorado Children And Pregnant Persons;" HB 23-1300, "Continuous Eligibility Medical Coverage;" and HB 22-1302, "Health-care Practice Transformation." Over the last six budget cycles, HCPF has also identified an opportunity to enhance several administrative functions by repurposing funding already appropriated for contractor resources to hire FTE to perform the duties instead. This contributed to an increase of 76.0 FTE (including HCPF's current R-14 request) for net General Fund savings of $439,631.

51. [Sen. Kirkmeyer] What are the specific requirements of this request element that require additional FTE?

RESPONSE

County and Case Management Escalations Unit

To be responsive to feedback and concerns from providers, advocates, members and other stakeholders, HCPF requested term-limited supplemental funding from the JBC and leveraged American Rescue Plan Act (ARPA) funds to create a single Escalation Resolution Unit/Team to assist members facing barriers to coverage renewal or falling through the cracks during the financial and functional eligibility process, driving timely resolution of administrative complexities, including Long-Term Services and Supports (LTSS). Regardless of the barrier the member/family is encountering through the eligibility or LTSS process, the Escalation Unit creates a seamless process for member issues to get resolved – *with a 90%+ coverage approval rate* - while working in collaboration with counties and Case Management Agencies (CMAs).

The new escalation unit vastly improves the outcome and timeliness of handling individual complaints reflecting families who were disenrolled or are about to be disenrolled but do not agree with that determination. The Escalation Unit creates one process and team that receives and resolves members' eligibility issues in collaboration with counties and CMAs. With this team in place, any Medicaid member or applicant, or their advocate or provider, can escalate their complaint or struggle to HCPF in a way that: 1) streamlines complaints through one process; 2) improves timeliness of responses and resolutions; 3) monitors data to identify

system issues and barriers; 4) informs systemic advances and stabilization efforts for individuals experiencing barriers to services, including LTSS and HCBS waiver services.

HCPF will continue to work with members, providers, RAEs, advocates, counties, CMAs and other community partners to incorporate feedback and refine the escalation process to ensure it is most effective and efficient in overcoming barriers and case specific complexities to ensure an accurate determination. More information on the number of escalations received and why these resources are essential to keeping members enrolled is on question 52. Moving to FTE enables the individuals working the cases to be able to access CBMS. Contractors cannot.

To continue to ensure timely access for all members, including LTSS members, HCPF is requesting 4.0 permanent FTE and contractor staff to handle member escalations. These positions are necessary for the following reasons:

- **Employee Type Requirement: Updating member information in CBMS can only be performed by governmental, merit-based employees.** Without these FTE positions, Escalation Resolution process is less efficient now than it could be by migrating contractors to FTE, thereby enabling efficient adjustments straight into CBMS as the findings are identified or barriers overcome. Conversion to FTE reduces bottlenecks and resolution time.
- **County/Case Management Agency (CMA) Burden Reduction:** As the requested FTE address the complexity or barrier, and make case adjustments straight into CBMS, that alleviates the inefficiencies and bottlenecks at the county/CMA staff level by mitigating duplication of effort. This shift enhances workflow efficiency and reduces delays for both members and county/CMA partners.
- **Financial and Functional Review:** Ongoing HCPF resources allow for a state-level optics and review of IT systems that are not visible to both counties and CMAs at the same time. A state level review of financial (county) and functional (CMA) eligibility can oftentimes be the most efficient way to identify a problem's root cause and the timeliest resolution to the betterment of the member/family and care provider.
- **Management of the Salesforce Escalation System:** Contractor staff are necessary to build, maintain and adjust the Salesforce system which is used to track escalations. Moving from excel spreadsheets to a systemic solution is appropriate given the size of the medical assistance new application and renewal volume and the continued Case Escalation volume post the PHE Unwind.
- **Customer Service:** The requested resources would continue to streamline and address complex case escalations that have not been addressed through the typical county or CMA avenues.
- **Root Cause Analysis and Data:** Ongoing HCPF resources would continue to improve timeliness of responses and resolutions, create data to identify system issues and barriers, and inform improvement and continued improvement efforts.
- **Non-Discrimination and Auxiliary Aids and Services:** Ongoing HCPF resources for county escalations will allow the state to be more responsive to concerns of

discrimination by applicants or members, and to ensure that Coloradans needing access to auxiliary aids and services, including those with Limited English Proficiency, receive the services they need through ongoing escalation reviews of counties.

Create Opportunities for State and County Collaboration

There is a lack of dedicated staff to respond to county/CMA eligibility questions, especially with complex cases. Current eligibility systems and policy staff are at or over capacity with their regular duties and cannot take on the volume of requests that HCPF has received, leading to delays in responses. HCPF requests 1.0 FTE to provide direct staff support for counties and case managers with complex cases or cases where policies or system data entry requirements are misaligned. These cases are separate from quality assurance and quality control cases and require extensive root cause analysis, coordination across multiple programs and IT systems to inform decision making going forward.

Develop Business Process Standards for Public and Medical Assistance Program

The state currently does not have business process standards for its public and medical assistance programs. As a result, it is possible various counties have different ways that business is conducted, leading to an uneven and unequitable delivery of these programs in each county. It is crucial that HCPF and DHS establish a series of business process standards that all counties must employ by developing county business process standards, implementing standards in rule and contracts, and aligning administrative requirements with the DHS divisions that also conduct county oversight.

For this, HCPF requests 1.0 FTE to help establish the criteria that HCPF and counties can use to evaluate their performance against the standard and determine measures for evaluating performance and how that data will be collected and reported. This is also addressed in question 56 in relation to requests for more standardization across counties for Medicaid programs; HCPF also provides further information on the federal requirements for consistency in administration.

Improve Policy Documentation and Dissemination

Current policies, regulations, and training materials are stored in different locations, certain processes may be different or not overly transparent between DHS and HCPF, and regulations are difficult to understand based on the language that is used. As such, there is a high need for HCPF to improve the overall policy documentation and dissemination process for the counties. All levels of county staff rely on Colorado's administrative regulations to guide their work and answer questions. However, county feedback indicated that administrative regulations are written in a very formal and legal syntax and each program area has its own set of regulations, which may be misaligned across the departments.

To mitigate this, first, HCPF requests 2.0 FTE to manage and direct a one-stop-shop portal and policy manual process, and improve collaboration, broader communication, toolkits, websites, templates, and engagement with the counties. These positions will ensure all stakeholders are involved in policy change discussions and creating policy materials and provide ongoing policy documentation and dissemination.

Program Area Natural Dialog Assistant (PANDA)

One of the initiatives in HCPF's R-07 budget request is to implement Program Area Natural Dialog Assistant (PANDA), which is an artificial intelligence (AI) policy bot that would allow functionality within CBMS that searches Departmental rules and regulations and provides a structured response to complex policy questions. PANDA would provide an automated intelligence solution that will search its resource database to provide consistent automatic responses without the need for manual intervention. Quicker response time and consistent messaging will assist in the proper and timely eligibility determinations and renewals for applicants and members.

HCPF requests 1.0 FTE to ensure the initial implementation of the medical assistance program information in PANDA is accurate and current, while functioning as the main point of contact for the CBMS vendor. Ongoing, the position will maintain the information database, monitor its performance and efficiency, identify any trends from the requests, create or revise FAQs, and propose new training topics to address any issues.

CBMS Additional Pool Hours

HCPF requests an ongoing investment of an additional 20,000 pool hours on an annual basis (5,000 hours per quarter), or a 10.0% increase to existing pool hours, in order to catch up on some of the backlog of projects, address several critical system challenges voiced by the counties, and increase automation capabilities, thereby bringing CBMS closer to a state where issues can be addressed closer to real-time. Once HCPF can catch up on project backlog, the additional pool hours will allow enhancements to reduce the manual intervention touchpoints and provide quicker turnaround responses to workers, partners and members to improve the eligibility determination process. Ongoing pool hours would allow HCPF to stay current with system changes and provide dedicated pool hours for projects that have a positive impact for counties.

The increase in pool hours also requires HCPF to correspondingly increase the number of staff to plan, implement, and oversee CBMS enhancements, ensuring the projects work in alignment with state and federal policy. Specifically, HCPF requests 7.0 FTE to ensure that HCPF has adequate resources to manage the added workload and the ability to review new code and releases. This includes:

- 1.0 UAT Tester to test every system enhancement and certify each for the releases and do back-end testing to ensure that any enhancements do not break existing functionality.
- 1.0 Systems Team Analyst to dictate and guide the systems project based on Medical Assistance program needs.
- 1.0 PEAK Analyst to manage projects impacting PEAK, identify user experience (UX) best practices for visual designs and impacts on the integrated product work for users, ensure stakeholders are engaged, and review language enhancements. Analyst will serve as integrator between policy, CBMS operations, and intuitive smartphone interactions of people accessing benefits.

- 1.0 Policy Subject Matter Expert to ensure the appropriate Medical Assistance (MA) eligibility policy is being applied appropriately within the systems project.
- 1.0 Eligibility Operations Analyst to help integrate any MA change into eligibility site business processes, workflow, monitoring, communication, and continuous improvement, ensuring maximum operational and business process benefit of the change.
- 1.0 Eligibility Policy Supervisor is needed as adding additional eligibility policy staff will become unmanageable by one existing supervisor.
- 1.0 SDC Training Developer to create and develop all training materials for eligibility site workers. This includes but not limited to desk aids, web-based trainings, webinars, instructor led materials, etc. All materials must be in compliance with accessibility requirements.

CBMS Automation and Innovation Initiatives

HCPF, in collaboration with CDHS, has identified several opportunities to automate and innovate current processes for medical assistance, SNAP, and CDHS financial programs and enhance support for the eligibility sites. These initiatives go beyond the need for the compliance required systems changes and will lead to increased modernized eligibility systems to improve timely processing, enhanced member experience, and enhanced eligibility worker experience.

HCPF requests 1.0 FTE that would participate in the oversight and administration of the initiatives by assisting in the application, and utilization of policy, systems and operational requirements that are administered by HCPF based upon HCPF principles and standards. The position would write operational procedures and operational memos through research to identify best practices & specific initiative operational needs and monitor performance. The position would coordinate, train, and facilitate technologies, people, and processes that relate to the delivery of the initiatives, along with providing essential consultation to management before deciding broad, critical program direction.

52. [Rep. Bird] What are the reasons for the increases in escalations that are driving the Unit's workload?

RESPONSE

Escalations to HCPF to address member challenges related to the eligibility determination process for financial and functional eligibility increased dramatically during the Public Health Emergency (PHE) unwind. Prior to the unwind, HCPF had no dedicated team to address escalations, requiring most to be redirected back to the county eligibility site or case management agency (CMA) for assistance, despite the consistent volume of issues submitted. Due to the enormity of demand during the PHE unwind, HCPF, leveraging funding from the PHE supplemental budget request and the American Rescue Plan Act, created a single internal unit to respond to the resulting increase in escalations.

The FTE and contractor resources requested in R-07 represent the resources needed to respond to the continued baseline level of escalations, which have continued after the end of the PHE unwind. Additional resources put in place to manage the excess demand during the PHE will be discontinued in June 2025.

Complaints and escalations around financial and functional eligibility have always existed, yet HCPF has never had the capacity or resources to support members who needed assistance beyond what could be offered by the county or CMA. The demands over the past two years have demonstrated the need for a continuation of this support at the state level. HCPF has also set up a streamlined process for the submission of escalations and worked with community partners to develop and improve the intake form and processes, with the goal of having a simplified and cohesive process for escalating complex situations. Decommissioning the state escalation process would lead to confusion about where to go to resolve issues, as well as an increase in workload for the counties and CMAs.

The main reasons for the increases in escalations include the following:

Financial Eligibility - The primary reason for the creation of the escalation unit was because of increases in county escalations earlier this year from the PHE Unwind. The PHE Unwind saw a large increase in members asking HCPF for support in navigating the county eligibility process. Those elevated numbers are listed below. However, the PHE Unwind ended in June 2024, and since then, the number of members asking for financial eligibility support decreased yet remains stable around 600 per month. HCPF expects that this number represents what a normal volume of financial eligibility escalations will look like moving forward. The reasons for HCPF receiving a financial eligibility escalation do not primarily relate to CBMS or system downtime issues, as HCPF responded to in question 56.

Functional Eligibility – Case Management Agencies (CMAs) are responsible for determining a member's functional eligibility. CMAs have been impacted by LTSS systemic challenges on top of the PHE Unwind, including:

- The implementation of IT system changes that resulted in additional workload and frustration for case managers; and
- Unanticipated complications with the transition of members to new case management agencies (CMAs) to achieve conflict-free case management.

The impact of these occurring at once - which was not intended - caused short-term challenges to member eligibility, CMA processing and member service response time, as shown by the increased number of escalations between February and May 2024. As noted above, the total number of escalations has stabilized since June 2024 to a range that HCPF would expect in normal operations.

Table 1: Financial/Functional Eligibility Escalations/Complaints Queue	
Month	**# Escalations/ Complaints**

January 2024	760
February 2024	956
March 2024	1039
April 2024	1054
May 2024	910
June 2024	617
July 2024	680
August 2024	698
September 2024	558
October 2024	630
November 2024	594

53. [Sen. Kirkmeyer] The funding for the County Escalations Resolution Unit is term-limited to the end of the current fiscal year. Why is this request seeking ongoing funding for permanent state employees and contract resources?

RESPONSE

The R-07 decision item requests to make the County Escalations Resolution Unit's functions permanent because it is very successful and highly coveted by advocates, providers, RAEs, CMAs, HCPF, and most especially by the members who were successfully approved for coverage through the Escalation Process. This Escalation Resolution Process has a 90% financial eligibility approval performance result – during and after the PHE Unwind – in preventing members from falling through the cracks and being denied coverage inappropriately when the member, provider, advocate, RAE or CMA accessed it to address an eligibility processing barrier or challenge. The Escalation process is a best practice that should be continued as well as advanced through R-7.

The Escalations Resolution Unit was established during the Public Health Emergency (PHE) Unwind, and subsequent LTSS Stabilization, because there were members who completed required actions but still faced barriers in maintaining their coverage or being reconnected to coverage after being disenrolled inappropriately. The Escalation Resolution Process enabled members, providers and advocates to have an avenue to get help for a member through HCPF when their case was stuck, denied in a way that seemed incorrect, when they couldn't get through to the county to address their issue and more. Without this Escalation Resolution Process, these individuals and families could have faced disenrollment, loss of access to services, and potentially face life threatening situations, because of process barriers for financial and functional eligibility at counties and Case Management Agencies (CMAs).

The chart below shows the number of case escalations processed, illustrating that while the Escalation volume was higher during the PHE Unwind (through June 2024), case escalations post the PHE Unwind continue – with the same 90% success rate.

Escalations Volume

Table 1: Financial/Functional Eligibility Escalations/Complaints Queue	
Month	**# Escalations/ Complaints**
January 2024	760
February 2024	956
March 2024	1039
April 2024	1054
May 2024	910
June 2024	617
July 2024	680
August 2024	698
September 2024	558
October 2024	630
November 2024	594

Escalation Resolution Unit resources going forward will serve to: transform contractor resources to FTE so they are able to use CBMS, which greatly improves effectiveness of the process; support and refine the Salesforce case escalation tracking tool, replacing individual excel files used to communicate between vendors, HCPF and each county; advance root cause analysis for systemic fixes that address and mitigate processing barriers going forward; and, improve the member experience of using the Escalation Resolution Process.

Pre-PHE, the medical assistance renewal approval average was 57% (calendar years 2018 and 2019). Post the PHE Unwind, the renewal approval rate is over 76%. Renewal automation, system advances, and new best practices like the Escalation Resolution Unit are driving these significantly improved performance outcomes – to the betterment of members, providers, churn reduction, and the state's coverage rates. Failure to fund these resources would result in the process being decommissioned, as HCPF has no resources to keep these processes in place otherwise. The decommissioning of this process would reinstate barriers for Coloradans attempting to keep their coverage, causing unnecessary churn which increases administrative processing expenses while increasing inappropriate disenrollments impacting individuals and families who cannot successfully overcome barriers to coverage approval, including our most vulnerable LTSS members.

54. [Sen. Kirkmeyer and Rep. Amabile] The three "quick wins" identified by the S.B. 22-235 assessments and studies seem to be activities that should be conducted in

the normal course of supervising the administration of medical assistance programs. Why are additional funding and resources needed for these recommendations? If the requested funding is provided, how will that affect the provision of services to individuals? How will these additional resources reduce bureaucratic barriers for county eligibility workers and individuals seeking services?

RESPONSE

Outside of the specific area of county concerns related to complex cases, HCPF **has not requested** any additional resources for implementation of the "Quick Wins."

The "Quick Wins" and "Transformative Recommendations" developed in the SB 22-235 Year 1 Assessment of Best Practices[40] were developed by a third-party vendor based on a large amount of feedback, especially from counties. HCPF agrees that the three "Quick Wins" are activities that the state undertakes as part of our regular work, it was critical to counties that these be documented in the report. Most of the work related to the "Quick Wins" is already resourced and is not included in the R-07 request. However, there is one component that is reflected in R-07, and that is the support HCPF provides to counties on complex cases. "Quick Win #1" relates to opportunities for the state and counties to better collaborate; counties identified this as essential for HCPF to provide additional support on.

Currently, HCPF has 1.0 FTE that provides eligibility policy, systems and operations support to counties through the state's eligibility inbox. This position is structured as a generalist, which means they must know all HCPF programs. However, both counties and HCPF recognize that the complexity of cases for Long-Term Services and Supports (LTSS) and other complex eligibility determinations requires additional assistance and that HCPF's current process requires necessary improvements to effectively support members, counties and case management agencies. Therefore, the only resources requested for the "Quick Win" relate to the assistance counties have requested from HCPF related to ongoing support for complex cases where direction is not always clear from ambiguous federal regulations.

55. **[Sen. Kirkmeyer] Please discuss the strengths and weakness of the prescribed funding model. How does the Department plan to address the limitations of the data used to develop the funding model? What improvements to the research and data collection methods are being considered for the next iteration of the funding model? Will the Department seek updated workload and timeliness data for the next iteration of the funding model?**

RESPONSE

HCPF believes the strengths of the funding model lay in the county data that was collected and the participation of the counties in the development. Much of the data collected from counties around expenditures provides the most comprehensive view of the costs associated

[40] drive.google.com/file/d/1a7k3sFPGjncS52mu-F1fLSBfaT1JZ_l-/view?usp=sharing

with administering HCPF's programs. From HCPF's perspective, two of the weaknesses of the funding model are: (a) that it cannot project future needs, because it is based on previous years' data, and (b) that it aggregates funding for regular Medicaid programs with funding for Long-Term Services and Supports (LTSS). HCPF has requested funding in the R-07 request to modify the funding model to address these concerns.

One of the concerns reported by counties was the use of data from the time study completed in 2017; however, this was not used as a data point to create the model. Rather, it was solely used to allow for like-comparisons across counties. That being said, HCPF and CDHS will be working to determine whether existing funding will allow for an update to the 2017 time study or whether that will need to be requested through the budget process.

For the annual updates that are required for the funding model, the expectation is that updated workload and expenditure data will be used. This would allow for the most accurate, recent data to be used for input into the funding model. HCPF and CDHS expect to work with counties on regular data collection that will be needed for the annual funding model update.

56. [Rep. Taggart and Sen. Kirkmeyer] Do the performance issues experienced by CBMS contribute to the number of complaints the County Escalations Resolution Unit have to address? How will the proposed development initiatives address the factors driving complaint volume?

RESPONSE

According to a root cause data analysis of escalations received from applicants and/or members regarding county financial eligibility from December 2023 to July 2024, only 4.7% of complaints were related to CBMS/PEAK, including help desk tickets for all systems issues, not just downtime or other IT systems-related issues.

Root cause analysis data demonstrates that the vast majority of county-related complaints received by HCPF relate to the ability for counties to keep up with workload, answer and return calls timely, or ensure their staff are connected to the right training resources. Most of the root causes, as determined by the analysis, found that they were county-specific, such as language line access or delayed processing of a case change, rather than systemic downtime or functionality issues. Because the data demonstrates that the vast majority of complaints are not related to CBMS, HCPF does not anticipate that the planned CBMS enhancements will materially reduce complaint volume received through the member escalations process.

Many of the proposed CBMS development initiatives would likely have minimal influence on member complaints:

% of Total	**Primary Root Causes for County-Related Escalations** *December 2023 through July 2024*

41.6%	**County Performance (Backlogs/Timeliness)**: These escalations were received because the member's eligibility was terminated, or about to be terminated, due to county backlogs, application/renewal timeliness or that the applicant/member submitted documentation that was not acted upon timely.
20.8%	**County Training**: These escalations were received because of training issues. County staff misinterpreted policy/regulation/sub-regulatory guidance; county staff encountered data entry issues; county staff did not have the correct policy/process information.
17.0%	**Member Communication Challenges with Counties**: These escalations were received due to member communications challenges with counties, such as being unable to get through to county call centers; unreturned calls from the county; unable to get additional assistance when needed.
8.2%	**LTSS/Transition from MAGI to LTSS**: These escalations were received due to challenges with transitioning from MAGI to LTSS. This includes issues with ARG/disability determination; Level of Care from CMA; provider billing issues resulting from CMA transition.
5.7%	**Member Related**: These escalations had the member reporting a county issue, but HCPF found no county issue. Rather, these are likely escalations where the county requested additional information from the member, but that information was not submitted.
4.7%	**System Issues**: These escalations had related help desk tickets; reported mailing issues with renewal packets; correspondence concerns; various system issues with CBMS/PEAK.
1.9%	**Other**: Various other issues not included above, including general inquiries and issues related to other agency-caused errors.
100.0%	

57. [Sen. Amabile] Please provide the out year costs specific to each element of the request associate with CBMS development.

RESPONSE

The following two tables show the CBMS costs associated with the FY 2025-26 R-7, "County Administration and CBMS Enhancements," for FY 2026-27 and FY 2027-28 and ongoing. The figures include corresponding costs from the Department of Human Services as well.

Costs that are ongoing costs for CBMS pool hours would allow HCPF to stay current with system changes and provide dedicated pool hours for projects that have a positive impact for counties. The ongoing automation and innovation initiatives funding would cover the maintenance of operation and licensing fees associated with the initiatives.

FY 2026-27 CBMS Development Costs in R-07						
CBMS Initiative	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Additional 20,000 Pool Hours	7.0	$3,744,203	$356,767	$198,880	$95,465	$3,093,091
Replace Current Data Syncing Technology & Implement Advanced Monitoring	0.0	($850,356)	($159,600)	($55,820)	($143,376)	($491,560)
Automate User Acceptance Testing	0.0	$69,627	$13,067	$4,572	$11,739	$40,249
Automation & Innovation Initiatives	1.0	$3,548,870	$563,865	$214,292	$442,124	$2,328,589
Total	**8.0**	**$6,512,344**	**$774,099**	**$361,924**	**$405,952**	**$4,970,369**

FY 2027-28 & Ongoing CBMS Development Costs in R-07						
CBMS Initiative	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Additional 20,000 Pool Hours	7.0	$3,744,203	$356,767	$198,880	$95,465	$3,093,091
Replace Current Data Syncing Technology & Implement Advanced Monitoring	0.0	($850,356)	($159,600)	($55,820)	($143,376)	($491,560)
Automate User Acceptance Testing	0.0	$69,627	$13,067	$4,572	$11,739	$40,249
Automation & Innovation Initiatives	1.0	$2,733,374	$510,380	$181,926	$442,124	$1,598,944
Total	**8.0**	**$5,696,848**	**$720,614**	**$329,558**	**$405,952**	**$4,240,724**

58. [Sen. Bridges] Given the consistent criticisms and complaints regarding the performance and accessibility of CMBS, has the option of building a new system from scratch been considered? If so, what are the considerations and costs of a new system versus continue to address incremental improvements in the current system? Is the underlying architecture and coding of CBMS sufficient to meet the needs and challenges faced by the counties that use the system?

RESPONSE

After completion of the CBMS Stakeholder Inventory[41] and analysis in 2022, an Alternatives Analysis[42] was conducted by consultants to explore various iterations of the potential path forward. That analysis indicated the prudent path was to continue to build and improve upon the state-owned system rather than initiate new system procurements and transitions.

The CBMS ecosystem has been modernized, leveraging SalesForce, Amazon Web Services and rules engine technologies. Automation processing innovations are also progressing admirably (above 60% overall and about 70% for MAGI), with Medicaid and CHP+ renewal approval rates at their highest in decades (76% and above) and renewal denials at levels that are half of pre-pandemic performance.

Further, eligibility ecosystem advances are funded and underway, such as the Joint Agency Interoperability project, which creates unified document capture, application and renewal tracking, and workflow task tracking in unified systems across all counties and processing partners. These innovations will begin implementation in FY 2026-27.

Colorado also boasts a feature desired by all other states – ONE system that processes public service eligibility. Trying to replace the entirety of that system is unnecessary, extraordinarily costly, and would create very disruptive transitional and training milestones for members, processors, county and Medical Assistance site managers and leaders, and all intermediaries. It would also take years to accomplish. Last, while it would likely address some of the current system opportunities, it would surely cause other challenges.

Addressing current system opportunities, like downtime, correspondence clarity, digital tools and the like is the preferred approach, thereby building off of and advancing the current system, as identified in the 2022 study noted above. The CBMS ecosystem modular procurement that we are undertaking enables us to do just that. Further, in tight budget times like these, HCPF's R-7 budget request recognizes and prioritizes the importance of investing in our counties – in their people – increasing the number of workers and their wages, which will enable counties to properly hire, train and retain qualified staff.

Our modularization CBMS ecosystem procurement approach allows the possibility of a compromise: making significant improvements to pieces of the system as needed, and on an iterative basis, while investing in our county partners. Concurrently, HCPF, CDHS and our new CBMS product lead are working on a technical health assessment, along with an assessment of usability, governance, and operations. That work will provide a clearer outline of improvement opportunities to inform and advance our procurement as well as parallel opportunities to improve CBMS productivity and performance.

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[41] drive.google.com/ ile/d/1FDb95Yq_1VWx7ABJS5Ss3eUrqvlqybHP/view
[42] drive.google.com/ ile/d/1C_z353WQJ4CYIlRQZx992-aDN040izar/view

	Pre pandemic	Unwind	Post Unwind					
	CYs 2018-2019	May 2023-April 2024	May 2024	June 2024	*July 2024	Aug. 2024	Sept 2024	Oct 2024
Renewal Rate	57%	55% (after 90- day reconsideration period)***	80% (after 90-day reconsideration period)	80% (after 90-day reconsideration period)	81% (after 90 days of the reconsideration period)	79% (after 60 days of the reconsideration period)	78%	77%
Auto Renewal Rate (ex parte, household level)	N/A	33% - All	59% - All **67% - MAGI	56% - All **66% - MAGI	62% -All **72% - MAGI	58% -All **68% - MAGI	63% - All **71% - MAGI	64% - All **70% - MAGI
Disenrollment Rate	41%	43% (after 90 days)	18% (after 90 days)	17% (after 90 days)	16% (after 90 days)	17% (after 60 days)	17%	18%
Pend Rate	2%	2-8%	2% (after 90 days)	3% (after 90 days)	3% (after 90 days)	4% (after 60 days)	5%	5%
Disenroll: Eligibility	29%	19% (after 90 days)	9% (after 90 days)	9% (after 90 days)	9% (after 90 days)	9% (after 60 days)	6%	8%
Procedural Disenroll:	12%	25% (after 90 days)	9% (after 90 days)	8% (after 90 days)	7% (after 90 days)	8% (after 60 days)	11%	10%

The health of a technology system can be evaluated by looking at criteria such as code complexity, maintainability, architecture, infrastructure, test coverage, automation, and more. As part of the CBMS reprocurement effort, we will be evaluating the CBMS ecosystem holistically, using our findings to inform improvements to performance, usability, accessibility, and cost efficiency, and incorporating those into our modularization and procurement strategy.

It should be noted that available pool hours are consumed by work to meet federal expectations, state legislative directives, and audit and compliance items. Those requirements, especially through the pandemic and unwind, have monopolized program FTE

resources. There is a backlog of work to be done that would benefit the counties. Much of it is around user experience, but those items continue to be deprioritized due to higher priority requirements from federal and state instructions. Modularizing the system is expected to result in efficiencies, but we will not see those in the immediate 1-2 years.

59. [Sen. Kirkmeyer] Counties are reporting significant and frequent CBMS outages. How are these outages addressed? How does the Department hold their 3rd party vendor accountable for the downtime of the system?

RESPONSE

CBMS performance can be affected by the quality of the code, the infrastructure and architecture that processes system requests and actions, and the amount of data involved. Over the past 10 months, the CBMS and vendor teams have been conducting root cause analyses on outage and slowness incidents experienced this year. Based on that analysis, they identified several actions they could take to address the issues, some of which have already been implemented, and others which are expected to be completed by the end of February. These actions are expected to significantly reduce incidents.

For example:

- Piloting options to improve county office bandwidth to address general internet delays and connectivity issues (in progress)
- Upgrading data infrastructure and expanding capacity (ongoing)
- Improving monitoring of query performance to prevent and address issues.

While we saw improvements over the course of the year from these actions, issues increased again in November and December. Additional steps we are taking or plan to take to address performance concerns and improve accountability include:

- Working with counties to ensure the inventory of downtime issues we are tracking is complete.
- Evolving current performance metrics – and executing reflective contract amendments - to better hold vendors accountable, along with improving expectations for, systems monitoring, testing, reporting, and communications between the vendor and OIT.
- Advancing our data retention and management policy, recognizing its potential impact on system processing time.

60. [Sen. Kirkmeyer] Will a portion of the 20,000 requested additional pool hours be used to address the reported CBMS outages?

RESPONSE

The additional 20,000 hours are intended as investments toward improving critical system challenges based on the user experience perspectives from both county workers and members. These pool hours are specific to projects for Medical Assistance programs in order to leverage the enhanced federal funding. The CBMS outages are being addressed through current appropriated funding for the maintenance of CBMS.

61. [Sen. Kirkmeyer] Is CBMS currently synchronizing with PEAK Pro and CCM? Have there been any performance issues with this synchronization?

RESPONSE

Yes, CBMS is currently synchronizing with PEAKPro and the Care and Case Management (CCM) system.

The performance issues reported for PEAKPro have included minimal issues directly related to PEAKPro and have been prioritized for expeditious fixes. The larger portion of the issues reported have primarily been associated with technical issues with CCM.

Successful integration between systems in the Colorado Medicaid Enterprise are critical to ensure data populates in all of the dependent systems correctly and timely. HCPF has been working with vendor partners to identify strategic solutions that drive more efficient and effective integration while focusing on addressing known issues to stabilize the CCM system. HCPF also procured an Enterprise Systems Integrator Vendor; this integration platform will be in production in December 2024, better enabling Medicaid system modules to integrate without defects. Some of the technical issues that are being addressed within the CCM impact how CBMS, PEAKPro, and the CCM systems work together. HCPF has prioritized resolving known issues and has developed an integrated roadmap and timeline across all vendors with the goal of reducing administrative burden for counties and case management agencies.

In addition, there has been ongoing support for users of the CCM system to help them overcome the learning curve for the new systems and processes. Since the implementation of Streamlined Eligibility in February 2024, HCPF has been hosting an open meeting to provide eligibility workers a forum to ask questions and obtain help specific to the CBMS, CCM, and PEAKPro connection. Subject matter experts from all areas regularly attend this meeting to provide support. HCPF has identified additional opportunities to enhance and streamline operations through innovation and technology and will pursue this as funding and prioritization allow.

PROVIDER FEES

62. [Sen. Kirkmeyer] How much of the Healthcare Affordability and Sustainability (HAS) Fee goes to each of the statutory purposes? How have these amounts changed over time?

RESPONSE

The proportion of Healthcare Affordability and Sustainability (HAS) fee by purpose (expansion populations, administrative expenditures, hospital payments, and other) from FY 2018-19 through FY 2023-24 are displayed in the graph and tables below as well as federal funds and total expenditures. The proportion of HAS fee needed for expansion populations changes to reflect changes in populations, utilization of services, and provider rates.

Chart 1. CHASE Expenditures by Use in millions

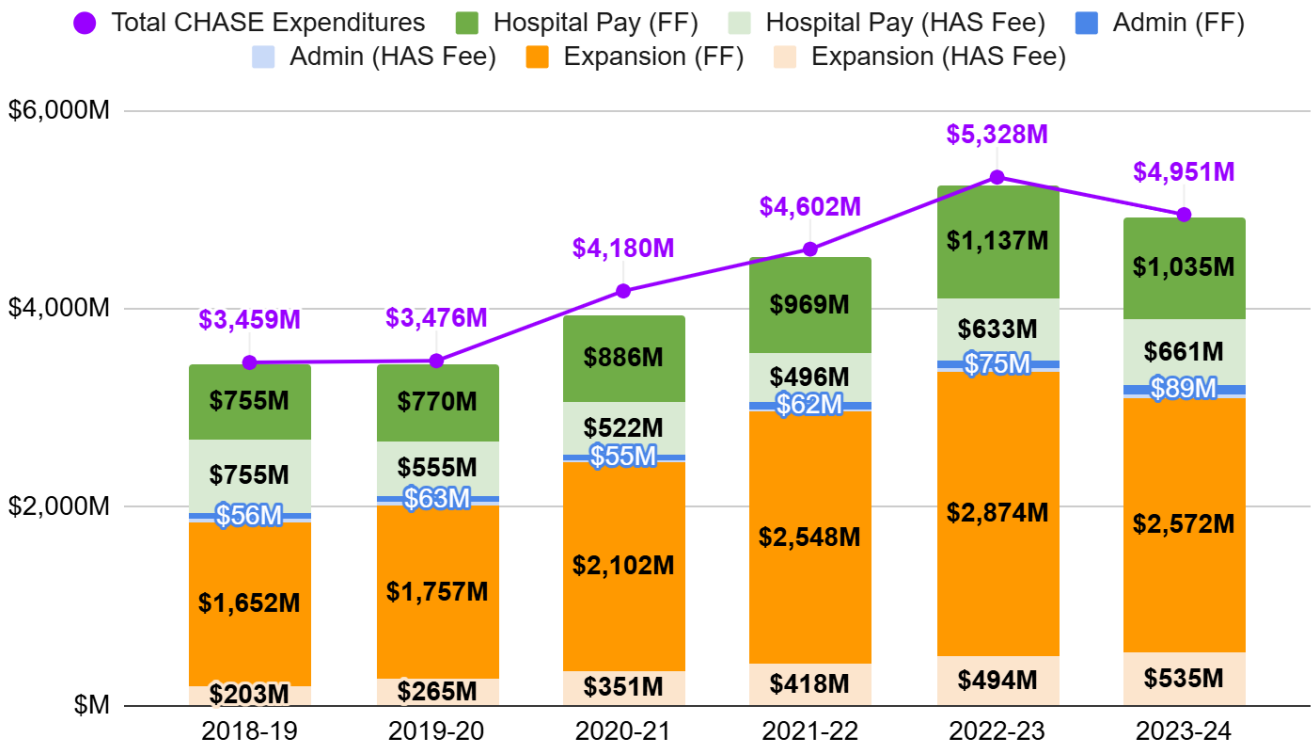


Table 1. HAS Fee and Federal Funds by Use in Millions

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Expansion (HAS Fee)	$202.7	$264.6	$351.3	$417.6	$494.3	$534.8
Expansion (FF)	$1,651.7	$1,757.2	$2,102.2	$2,547.7	$2,874.3	$2,572.2
Admin (HAS Fee)	$23.5	$26.1	$24.5	$27.0	$31.0	$35.9

Admin (FF)	$56.0	$63.2	$54.9	$62.0	$75.0	$88.5
Hospital Payments (HAS Fee)	$754.7	$555.4	$522.0	$496.4	$633.1	$661.5
Hospital Payments (FF)	$754.7	$770.0	$886.3	$968.7	$1,136.6	$1,035.3
Other*	$15.7	$39.6	$238.8	$82.8	$83.3	$22.4
Total CHASE Expenditures	**$3,458.9**	**$3,476.2**	**$4,180.0**	**$4,602.2**	**$5,327.5**	**$4,950.7**

*Other = UPL Backfill per §25.5-4-402.4 (5)(b)(VII), HB 20-1385 Use of Increased Medicaid Match, and ARPA - SB 21-286 Transfer

Table 2. CHASE Fund Splits in Millions

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
HAS Fee	$996.5	$885.7	$1,136.6	$1,023.8	$1,241.6	$1,254.6
Federal Funds	$2,462.4	$2,590.5	$3,043.4	$3,578.4	$4,085.9	$3,696.0
Total Expenditures	**$3,458.9**	**$3,476.2**	**$4,180.0**	**$4,602.2**	**$5,327.5**	**$4,950.7**

Table 3. Percentage of HAS Fee by Use

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Expansion	20.3%	29.9%	30.9%	40.8%	39.8%	42.6%
Admin	2.4%	3.0%	2.2%	2.6%	2.5%	2.9%
Hospital Payments	75.7%	62.7%	45.9%	48.5%	51.0%	52.7%
Other*	1.6%	4.5%	21.0%	8.1%	6.7%	1.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 4. Percentage of Federal Funds by Use

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Expansion	67.1%	67.8%	69.1%	71.2%	70.3%	69.6%
Admin	2.3%	2.4%	1.8%	1.7%	1.8%	2.4%
Hospital Payments	30.6%	29.7%	29.1%	27.1%	27.8%	28.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 5. Percentage of Total CHASE Expenditures by Use

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Expansion	53.6%	58.2%	58.7%	64.4%	63.2%	62.8%
Admin	2.3%	2.6%	1.9%	1.9%	2.0%	2.5%
Hospital Payments	43.6%	38.1%	33.7%	31.8%	33.2%	34.3%

Other*	0.5%	1.1%	5.7%	1.8%	1.6%	0.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

*Other = UPL Backfill per §25.5-4-402.4 (5)(b)(VII), HB 20-1385 Use of Increased Medicaid Match, and ARPA - SB 21-286 Transfer

63. [Sen. Kirkmeyer] How is the allocation of the HAS Fee by purpose determined and who decides?

RESPONSE

The allowed uses of the Healthcare Affordability and Sustainability (HAS) fee are expressly delineated in the Colorado Health Care Affordability and Sustainability Enterprise (CHASE) statute, specifically at § 25.5-40-402.4 (5), C.R.S., and are listed at the end of this response. All funds in the HAS fee cash fund are subject to annual appropriation by the General Assembly.

The Joint Budget Committee and General Assembly, HCPF, the CHASE Board, the Medical Services Board, and the Centers for Medicare and Medicaid Services (CMS) each have important roles in determining how the HAS fees and related federal matching funds are spent.

Joint Budget Committee and General Assembly

All funds in the HAS fee cash fund are subject to annual appropriation through the Joint Budget Committee and General Assembly. HCPF does not have discretion to expend HAS fees for purposes not outlined in statute or where expenditures have not been appropriated through the usual budget process. Further, HCPF does not have discretion to collect or expend HAS fees unless federal financial participation is approved, except where the expenditure of HAS fees without federal matching funds has been explicitly appropriated otherwise.

The Department of Health Care Policy and Financing

HCPF staff gather and analyze data to calculate the HAS fee and related hospital supplemental payments for consideration by the CHASE Board. HCPF develops HAS fee and payment proposals in line with federal requirements and the goals outlined in the CHASE statute to maximize reimbursement to hospitals, increase the hospitals benefitting from the HAS fee and minimize those that suffer losses, support improvements in the quality of hospital care, and fund expanded public health care coverage.

HCPF staffs the CHASE Board and prepares materials for the CHASE Board’s review and recommendations. HCPF staff prepare necessary rules for the CHASE program and present them to the Medical Services Board for adoption.

HCPF is the single state agency for the administration of Colorado’s Medicaid program and is authorized to draw federal Medicaid funds. HCPF staff prepare and submit all required

documents, demonstrations, and reports to CMS for federal approval, review, and oversight purposes.

CHASE Board

The 13 member CHASE Board appointed by the governor and confirmed by the Senate is the recommending body for the HAS fee and supplemental payments. Amongst other duties, the CHASE Board prepares and submits the CHASE Annual Report to the Joint Budget Committee, Senate and House Health and Human Services Committees, and others. The CHASE Board's specific duties are delineated in statute at § 25.5-4-402.4 (7), C.R.S.

Medical Services Board

The Medical Services Board promulgates rules necessary for the administration and implementation of the HAS fee with consideration of the CHASE Board's recommendations and in line with the Administrative Procedures Act. The Medical Services Board's role is described at § 25.5-4-402.4 (4)(g), C.R.S.

Centers for Medicare and Medicaid Services

CMS is the ultimate authority for approval of the HAS fee, hospital supplemental payments, Upper Payment Limit (UPL) demonstrations, and any other federal approval needed for the administration of the HAS fee. CMS approval of provider fee waivers, State Plan Amendments, demonstration waivers, quarterly accounting reports, Disproportionate Share Hospital audit reports, etc., are required for collection of HAS fees and disbursement of related payments.

CHASE Statute Allowed Uses of HAS Fee

As reflected at § 25.5-40-402.4 (5), C.R.S., the specific uses of the HAS fee are as follows:

- To maximize inpatient and outpatient hospital reimbursements to up to the federal upper payment limit (UPL)
- To increase hospital reimbursement under the Colorado Indigent Care Program to the cost of care
- To pay hospital quality incentive payments
- To expand eligibility for public medical assistance for
    - Parents and caretakers of children enrolled in Medicaid
    - Children and pregnant persons enrolled in Child Health Plan *Plus* (CHP+)
    - Adults without dependent children in the home enrolled in Medicaid
    - Children and working adults with disabilities through a Medicaid Buy-In Program
    - Twelve-month continuous coverage for children enrolled in Medicaid
- To pay the CHASE's actual administrative costs including, but not limited to, costs related to the hospital reimbursement, costs related to the claims system (MMIS) and eligibility system (CBMS) to implement and maintain the expansion of medical assistance coverage, and personnel and operating costs related to the expansion of medical assistance coverage including at county departments

- To offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008
- To provide funding for a health care delivery system reform incentive payments program, referred to as the Hospital Transformation Program
- Other additional uses of the HAS fee as the General Assembly otherwise designates, such as the amount of the increase in federal financial participation due to the Families First Coronavirus Response Act and the American Rescue Plan Act to offset general fund expenditures for the Medicaid program pursuant to House Bill 20-1385

64. [Sen. Kirkmeyer] Why has the amount for administration increased? What is the incremental increase in workload driven by the HAS Fee programs?

RESPONSE

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) program, like the provider fee program that preceded it, increases hospital reimbursement for care provided to Medicaid members and uninsured patients, improves the quality of hospital care, and finances the state obligation for the Medicaid expansion population earning up to 138% of the FPL (90% federal funds/10% state funds). Accordingly, CHASE helps expand health coverage and access through expansions to Medicaid and Child Health Plan *Plus* (CHP+) coverage for children, pregnant people, low-income adults, and children and working adults with disabilities. CHASE pays its actual administrative costs with no increase in General Fund expenditures.

All HAS fee-related expenditures, including administration, are subject to annual appropriation through the usual budget process. HCPF does not have discretion to expend HAS fees for purposes not outlined in statute or where expenditures have not been appropriated. As directed through the CHASE statute, the CHASE Board submits an annual report to the Joint Budget Committee, the Senate and House Health and Human Services Committees, and others including a detailed itemization of CHASE administrative expenditures. HCPF also provides a detailed CHASE Update as an exhibit with our Nov. 1 budget request.

HCPF's overall administration rate is about 4% of total expenditures with 0.5% expended on staff (FTE) costs. This 4% covers the traditional administrative costs associated with a health plan, including the administrative costs to support the Medicaid expansion population – like adjudicating their claims and reimbursing providers, managing provider networks, financing county eligibility staff and systems, answering provider and member calls, providing digital health plan tools for members, performing utilization review, maintaining network directories, creating new payment models, etc. Comparatively, this 4% Medicaid administration expense is about one-third of the cost of commercial carrier administration charges. In other words, commercial carrier administrative expenses are about 300% higher than HCPF’s to provide similar services. The Medicaid expansion members require the same

administrative services and supports, financed by CHASE dollars, as the traditional Medicaid members whose costs are financed by General Fund or other cash funds.

CHASE's administrative expenditures are capped at 3% administrative cost rate and expenditures are consistently below that amount. Changes in the dollar amount of CHASE administrative expenditures are tied to changes in the Medicaid program itself, just as changes in HCPF's administrative expenditures are tied to changes in the Medicaid program.

Given that coverage for 35% of Medicaid and CHP+ members are financed with HAS fees, and that the CHASE administrative rate is consistently below its 3% cap and lower than HCPF's overall administration rate, the state is likely under allocating administrative costs to the HAS fee. Consequently, the General Fund, contrary to legislative intent, is likely funding some of the administrative costs associated with the HAS fee.

CHASE Administrative Expenditure Trends

Per § 25.5-4-402.4 (5) (VI), C.R.S., CHASE pays its actual administrative costs including those costs related to the claims (MMIS) and eligibility (CBMS) systems to implement and maintain the expansion of medical assistance coverage, and the personnel and operating costs related to the expansion of medical assistance coverage including at county departments.

- In FY 2023-24, CHASE administrative costs totaled $124.5 million and were only 2.51% of the $4.95 billion total CHASE expenditures.
- Only 0.26% of CHASE expenditures were for the FTE who administer the program.
- The vast majority of CHASE administrative costs are related to information technology contracts and projects (namely MMIS and CBMS operating and maintenance costs) and eligibility determination and client services, which combined for a total of 78% of total CHASE administrative expenditures in FY 2023-24.
- The two largest CHASE administrative expenditures are for the operations and maintenance of the MMIS claims system and county eligibility administration at 28% and 24% of total CHASE administrative expenditures, respectively.
- CHASE administrative expenditures are funded by approximately 30% HAS fees and 70% federal funds.

The following charts and tables show the breakdown of total administrative costs by type and by fund splits: HAS fee cash fund and federal funds.

Table 1. CHASE Administrative Expenditures by Type
in millions

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
General Administration	$10.4	$14.1	$12.4	$14.7	$13.6	$20.3
Information Technology Contracts and Projects	$37.0	$43.2	$34.1	$36.3	$49.3	$55.5

Eligibility Determinations and Client Services	$28.8	$28.0	$27.1	$32.6	$38.6	$41.4
Other	$3.3	$4.1	$5.6	$5.5	$4.5	$7.2
Total Administrative Expenditures	**$79.5**	**$89.4**	**$79.4**	**$89.1**	**$106.0**	**$124.4**
Admin Expenditures % of Total CHASE Expenditures	2.30%	2.60%	1.90%	1.90%	1.99%	2.51%

Chart 1. CHASE Administrative Expenditures by Type

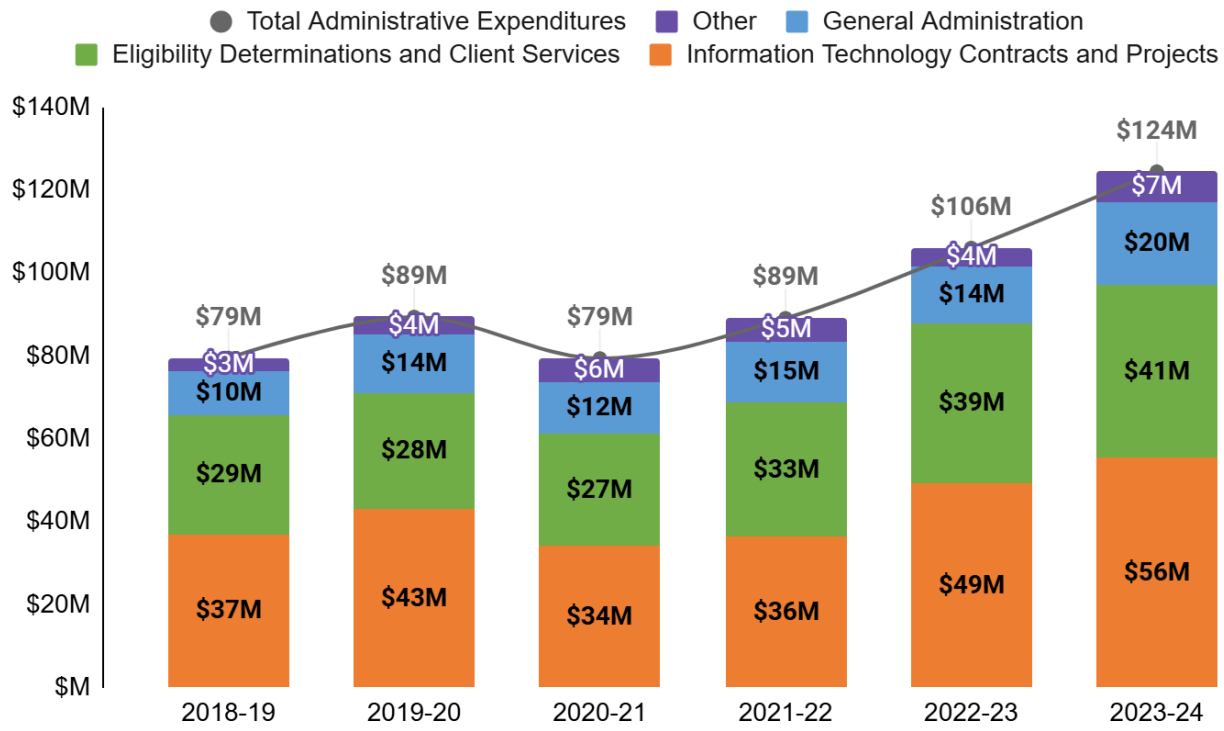
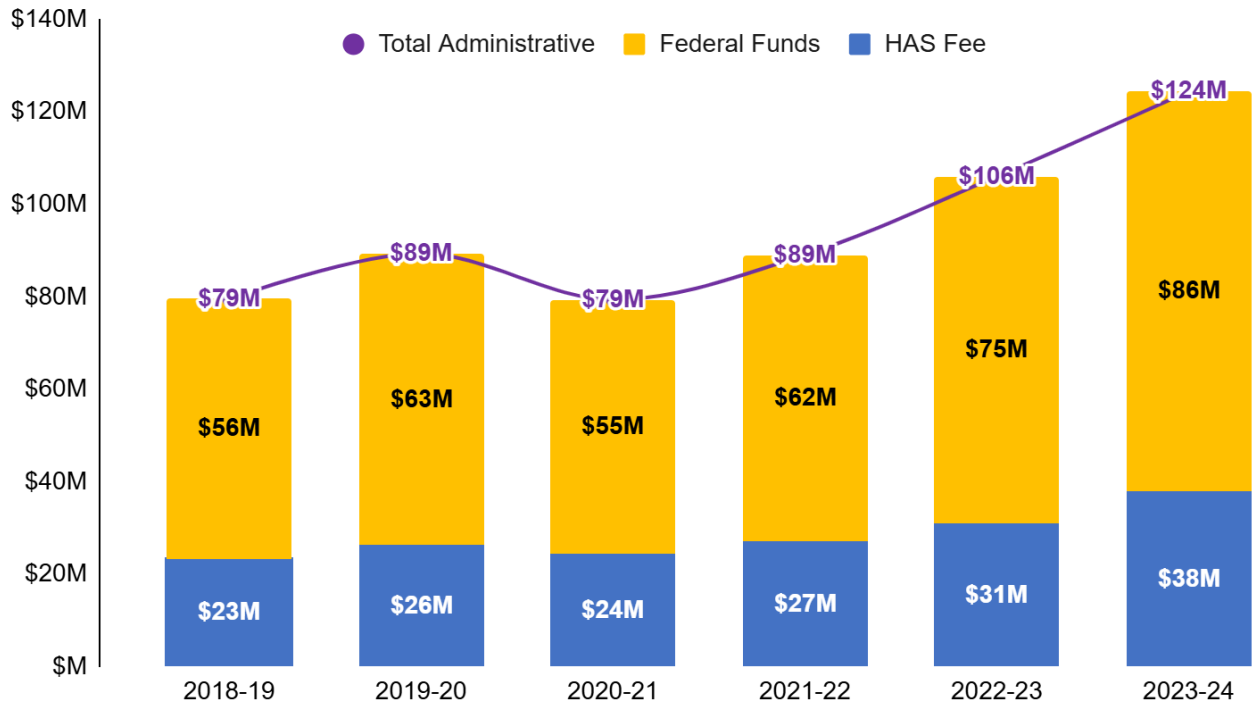


Table 2. CHASE Administrative Expenditures by Fund Split in millions

SFY	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
HAS Fee	$23.5	$26.2	$24.5	$27.0	$31.0	$38.0
Federal Funds	$56.0	$63.2	$54.9	$62.0	$75.0	$86.5
Administrative (Total)	**$79.5**	**$89.4**	**$79.4**	**$89.1**	**$106.0**	**$124.4**



65. [Rep. Bird/Sen. Kirkmeyer] In R10 the Department requests $2.6 million, including $1.3 million from the HAS Fee, and 6.6 FTE to increase administration of the HAS Fee. Why? What is driving the additional costs?

RESPONSE

In administering the CHASE, HCPF has identified a resource shortfall in critical staff such as analyst, auditor, and accountant roles, and a lack of adequate contractor support for expert consultation and system needs. A prior request, FY 2018-19 R-15 "CHASE Administrative Costs," addressed the newly created Enterprise via SB 17-267 by requesting additional administrative resources to support the enterprise status of the CHASE and comply with the bill requirement for the provision of specific business services to hospitals. Now, recent developments at both the state and federal level are driving another increase in workload that cannot be absorbed by existing resources.

The new federal requirements are the primary driver behind the need for additional resources. Despite the standard provider fee methodology being in place since 2010, and the basic payment structure largely the same for more than seven years, there are new CMS requirements, including increased scrutiny demands, requiring additional resources. Specifically, changes in federal regulations and policies are stipulating a stricter interpretation of language pertaining to critical calculations for both the assessment of the hospital provider fee and the optimization of the annual payment and distribution model. As a result, there is a corresponding increase in audits and reviews. Further, local stakeholder challenges to many of the underlying components of the model, including fee/payment

methodologies and hospital categorization, require additional resources to properly address and resolve.

In addition, because the CHASE Board direction, the Colorado Hospital Association's priorities, and the new federal requirements are all related and intertwined, the CHASE Board has formed a workgroup to develop recommendations to optimize the existing fee assessments and supplemental payments, to explore the addition of a State Directed Payment (SDP) component, and to ensure compliance with the new federal regulations. Additional resources are also necessary to perform the tasks driven by workgroup. Specific goals and requirements of the workgroup include addressing the following:

- CMS implemented new upper payment limit (UPL) demonstration reporting requirements and an annual review and approval process, increasing scrutiny on key federal requirements that govern the amount of increased hospital reimbursement.

- In 2023 and 2024, CMS also clarified and revised its policies concerning allowable provider fee programs and notified states it intends to increase engagement with states and review of these financing arrangements to ensure they meet existing and revised federal requirements.

Finally, effective July 2024, under 42 CFR 438.6(c), the managed care regulations were updated to clarify requirements for SDPs and to strengthen the provider fee hold harmless prohibitions associated with these payments. Specifically, these revisions bring forth the opportunity to develop and implement an SDP payment model that facilitates additional funds directly supporting hospital care provided through managed care contracts with Denver Health Medicaid Choice, Rocky Prime, and HCPF's behavioral health network.

66. [Sen. Amabile] What are the expansion populations financed with the HAS Fee? What are the match rates for each population? What percentage of the total Medicaid population do the HAS Fee financed populations represent?

RESPONSE

The table below shows the populations funded with the HAS Fee for the state share, the federal match rates, and the percentage of each population to the FY 2025-26 projected Medicaid enrollment of 1,286,949 members.

Population	Federal Match Rate	FY 2025-26 Estimated Population	Percentage of Total Medicaid Population
MAGI Adults	90%	346,248	26.90%
MAGI Parents/Caretakers 69-133%	90%	48,352	3.76%
Non Newly Eligibles	80%	4,130	0.32%

Buy-In for Individuals with Disabilities	50%	24,999	1.94%
Continuous Eligibility for Children	50%	18,927	1.47%
Parents/Caretakers 60-68%	50%	4,725	0.37%
Total		**447,381**	**34.76%**

67. [Rep. Bird/Sen. Kirkmeyer] How quickly could the Department implement a directed payment program to increase the federal funds available for hospitals? Please explain why it would take this long.

RESPONSE

HCPF assumes we need at least six months to develop a Directed Payment Program (DPP) proposal and associated materials for submission to the Centers for Medicare and Medicaid Services (CMS) for review and approval. Following submission, HCPF assumes it will take at least 90 days and as much as six months or longer for CMS approval. Implementation will follow federal approval and will be retroactive to the allowable effective date, at least as early as July 2025.

The hospital provider fee, through Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) and its predecessor program, have operated successfully for more than 14 years combined. Today, CHASE brings in more than $3.5 billion in federal funds to support health care for Coloradans, funds coverage for more than 400,000 Coloradans currently (and as high as more than 650,000 in the COVID-19 Public Health Emergency), and directly provides Colorado hospitals with additional federal funds of more than $490 million per year.

HCPF is committed to assessing a DPP and other reforms to CHASE as quickly as feasible while maintaining CHASE operations, health care coverage for more than 400,000 Coloradans currently funded through the Healthcare Accessibility and Sustainability (HAS) fee, and minimizing risk to the General Fund and loss of federal financial participation. This new undertaking represents a full evaluation and perhaps complete overhaul of how the HAS fee is assessed and how hospital reimbursements are made. The CHASE Board and HCPF must take the time necessary to develop a sound proposal while doing so as quickly as practical.

In late August, the Colorado Hospital Association (CHA) sent a request to HCPF to create a working group to explore the establishment of a DPP as well as reforms to the existing HAS fee and related supplemental payments. Following communication between CHA and HCPF leadership and CHASE Board discussions, the CHASE Board approved the creation of such a workgroup. The workgroup held its initial meeting on Dec. 16, 2024, and will meet at least twice monthly beginning in January.

The workgroup's objective is to develop comprehensive recommendations for revisions to CHASE, including the addition of a DPP, for CHASE Board consideration. The goal is for HCPF to advance a broadly supported proposal to submit to the federal Centers for Medicare and Medicaid Services (CMS) for implementation to begin effectively no later than July 1, 2025.

An outline of related federal timelines is below, followed by more details of the workgroup's activities.

Federal Timelines

Directed Payment Programs. CMS revised Medicaid managed care regulations effective July 9, 2024, including rules concerning DPPs. Some new requirements have staggered effective dates, including the timing for DPP preprint submissions. Currently, DPP preprints must be submitted to CMS prior to the end of the rating period for an effective date at the beginning of the period. This means a preprint submitted in June 2025 could have an effective date at the beginning of FY 2024-25, July 2024.

After July 2026, preprints must be submitted before the effective date. So, in the future, a preprint will have to be submitted prior to the beginning of the state fiscal year in which it is to be effective, i.e., submitted before July 2027 to be effective for the FY 2027-28.

Nonetheless, states remain at risk for a disallowance of federal financial participation until and unless CMS has approved the DPP preprint as well as the managed care contracts and capitation rates that include the payment arrangement.

State Plan Amendment. If a State Plan Amendment (SPA) is required to implement the approved proposal, the changes to the State Plan can be effective no sooner than the first day of the quarter in which the SPA was submitted, provided adequate public notice was made before the effective date. This means if public noticing of a proposed SPA occurs in June 2025, the SPA can be submitted by Sept. 30, 2025, and be effective July 1, 2025, following CMS approval. CMS has a 90-day timeframe to approve a SPA but may extend that by requesting additional information.

Non-Federal Funding Source(s). Part of the process for CMS to approve changes in payment methods through SPAs or DPPs requires CMS approval of the source of the non-federal share. Where sources other than General Fund appropriated by the legislature are used, such as provider fees or intergovernmental transfers (IGTs), CMS must review the fee or IGT arrangement and will not approve the SPA or DPP until it has approved the non-federal share.

1. **Fee Waiver**. If revisions to the existing fee methodologies are needed to implement the approved proposal, then HCPF will need to develop a new fee methodology that complies with federal requirements, including passing a series of statistical tests. This work requires substantial data analysis and modeling to ensure the new structure meets federal requirements, as well as feedback and input from affected hospitals. There is no time limit for CMS' review and approval of a state's fee waiver, and in our experience, the process from waiver submission through approval takes at least six months to complete. No changes in the fee methodology could occur prior to CMS' approval.

2. **Intergovernmental Transfers Agreements**. If IGTs are needed to implement the approved proposal, the General Assembly will need to appropriate those funds through the budget process. Moreover, HCPF will need to execute agreements with each public hospital transferring the funds. The IGT agreement(s) must be approved by CMS before it can be implemented.

Additional Workgroup and HCPF Activity Details

The workgroup has been tasked to complete the following between December 2024 and approximately May 2025:

- In line with the CHASE Board's directive, agree to a scope of work, timeline, goals, and ground rules for collaboration.
- Establish a common understanding among work group members about CHASE, DPPs, and federal guidelines.
- Develop and evaluate scenarios for a DPP for Colorado. This includes recommending funding sources, funding splits between the DPP and existing CHASE supplemental payments, type of DPP, etc.
- Develop and evaluate scenarios to revise or evolve the existing CHASE hospital provider fees and supplemental payments in line with the goals of CHASE to increase reimbursement to hospitals while maximizing hospitals benefitting from the provider fee and minimizing those who suffer losses.
- Develop mutually supported recommendations to address the creation of an DPP and/or reforms to Colorado's existing CHASE fees and supplemental payment program.
- Support the development of talking points for use by the CHASE Board, HCPF, and others.
- Provide any additional necessary input for materials to be submitted CMS.

The CHASE Board will receive briefings and updates on workgroup activity and provide input as necessary throughout the period stated above. The CHASE Board will approve the initial framework and contours of the proposal and will ultimately approve the final proposal for submission to CMS.

HCPF is a participant in the workgroup and will have additional execution responsibilities including:

- Coordinating with internal HCPF managed care staff to align quality goals with the state's managed care quality strategy
- Engaging and working with the actuarial team regarding managed care rate certification timing
- Conducting actuarial rate certification and adjusting monthly base capitation rates
- Incorporating DPP into managed care contracts
- Refining the proposal and preparing materials for submission to CMS, including a revised fee waiver request, State Plan Amendment(s), DPP preprint, and other associated materials such as upper payment limit and average commercial rate demonstration.

68. [Rep. Sirota] If the General Assembly converted the nursing provider fees to an enterprise, increased the fees to the maximum to draw additional federal funds for the nursing providers, and directed the department to minimize the negative impacts on nursing providers that don't benefit from the supplemental payments, then how quickly could the Department implement the change? Please explain why it would take this long.

RESPONSE

The current nursing facility provider fee calculation is set in accordance with 25.5-6-203, C.R.S., limiting annual fee increases to the national skilled nursing facility market basket index. If the General Assembly revises this statute and converts the fee to an enterprise, HCPF could draw additional federal funds. If no changes are made to the structure of the fee, then an increase in fees can be implemented in approximately six months allowing for calculation revisions, rule changes, and collection of additional fees from the nursing facilities.

However, there are 15 nursing facilities that do not provide care for Medicaid members and pay fees without receiving payments in return. This group of 15 providers would experience an average $2,500 per month increase in fees without benefit, which we could not mitigate unless we receive approval from CMS for a revised fee methodology. Revising the fee requires developing a new fee methodology that complies with federal requirements, including passing a series of statistical tests. This work requires substantial data analysis and modeling to ensure the new structure meets federal requirements, as well as feedback and input from affected nursing facilities.

Following the development of a new fee methodology, HCPF would submit the revised fee methodology and supporting workpapers to CMS for approval to waive the broad based and uniform fee requirements in Section 1903 of the Social Security Act. There is no time limit for CMS's review and approval of a state's fee waiver, and in our experience, the process from waiver submission through approval takes at least six months to complete. Therefore, if a change in fee methodology is sought, the total time for implementation will be at least one year to allow for calculation revisions, stakeholder engagement, CMS approval, rule changes, and fee collections.

69. [Sen. Bridges] Please explain the upper payment limit that constrains supplemental payments to hospitals. How has the percentage of the upper payment limit that is financed with supplemental payments changed? What was the fiscal impact to hospitals from this change?

RESPONSE

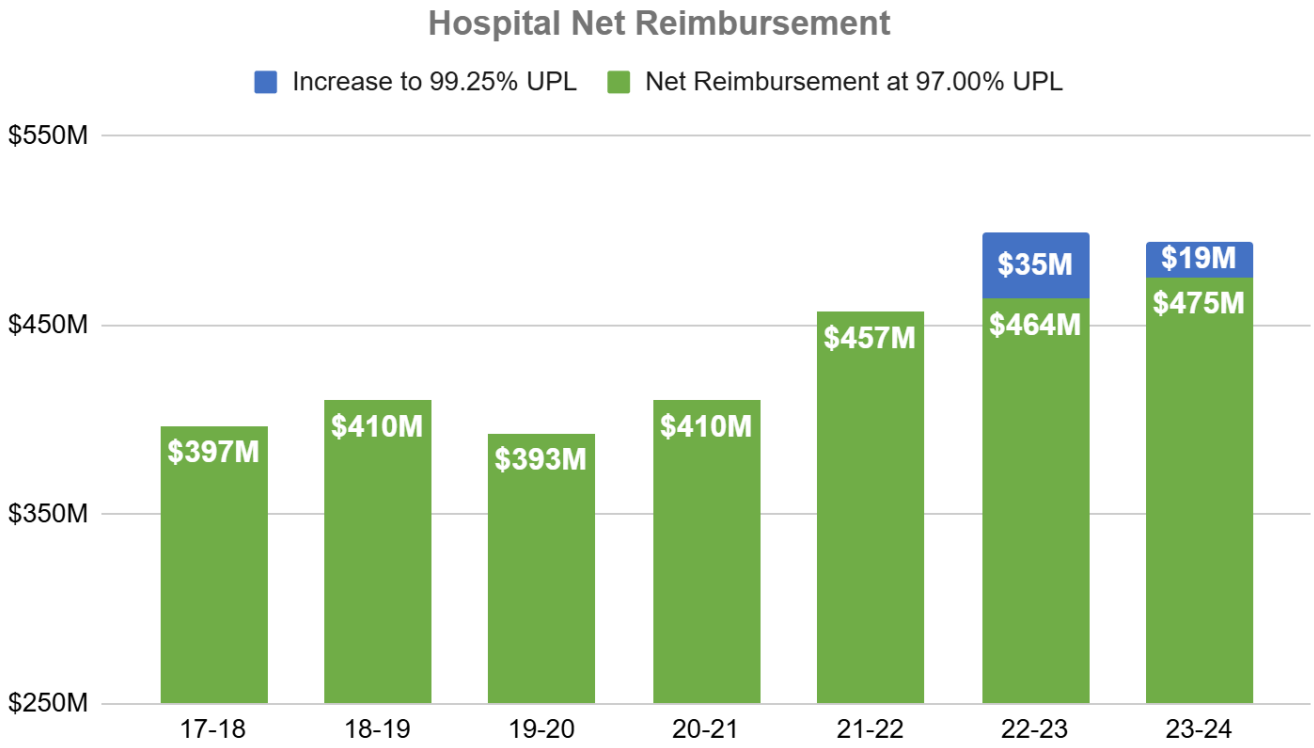
The sum of Medicaid claims-based payments and supplemental payments for hospital services cannot exceed a reasonable estimate of what would have been paid according to Medicare

payment principles. The upper payment limit (UPL) is a federally required limit on payments to hospital providers for Medicaid services. Hospital UPL demonstrations are submitted to CMS annually for their review and approval.

Historically, Healthcare Affordability and Sustainability (HAS) fee-funded supplemental payments have been calculated so that total hospital payments (claims-based payments + supplemental payments) equal approximately 97% of the available UPL.

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) operates on a federal fiscal year (FFY) basis. Following discussions between the Colorado Hospital Association, HCPF, and the Governor's Office, the CHASE Board recommended increasing supplemental payments such that total hospital payments now equal 99.25% of the available UPL. With the ability to retroactively draw federal funds under the two-year federal timely filing requirements, supplemental payments for FFYs 2022-23 and 2023-24 retroactively increased to 99.25% of the available UPL. For the two-year period, an additional $31 million in HAS fees were collected from hospitals and an additional $85 million in CHASE supplemental payments were made. This resulted in a net increase of federal funds of $54 million for Colorado hospitals: $35 million for FFY 2022-23 and $19 million for FFY 2023-24.

The graphic below shows hospital net reimbursement from CHASE for FFYs 2017-18 through 2023-24, with the increases in FFYs 2022-23 and 2023-24 from 97% to 99.25% of the UPL shown in in blue. The table that follows shows the increase in fees, payments, and net new funds by major hospital system in total for both years.



in millions	Add'l HAS Fees	Add'l Payments	Original Net Funds	Revised Net Funds	Add'l Net Funds
Banner Health	$0.8	$3.1	$67.3	$69.6	$2.3
AdventHealth	$2.2	$5.4	-$2.1	$1.1	$3.2
CommonSpirit Health	$4.2	$11.6	$58.2	$65.6	$7.4
Children's Hospital Colorado	$1.4	$4.2	$61.7	$64.5	$2.9
Denver Health	$1.1	$1.8	$188.4	$189.0	$0.6
HCA HealthONE	$6.9	$19.3	$26.3	$38.7	$12.4
San Luis Valley	$0.2	$0.9	$27.0	$27.7	$0.7
Intermountain Health	$3.3	$8.9	$83.9	$89.5	$5.6
UCHealth	$8.8	$17.3	$176.0	$184.5	$8.5
Encompass	$0.0	$0.0	$0.8	$0.8	$0.0
Kindred	$0.0	$0.0	$0.4	$0.4	$0.0
All Others	$2.3	$12.6	$251.5	$261.8	$10.3
Totals	**$31.1**	**$85.1**	**$939.4**	**$993.4**	**$54.0**

The CHASE statute, Section 25.5-4-402.4(6)(b)(II), Colorado Revised Statutes, prioritizes hospital payments over covering the cost for expansion populations. However, the precedent was set in FY10-11 with roughly $150M and in FY20-21 when HB20-1386 authorized $161M of CHASE cash fund as Medical Services Premiums GF offset.

In a shared decision ultimately approved by the CHASE Board to increase the UPL to 99.25%, $54 million in additional CHASE payments to hospitals was released in December 2024. This increase in the UPL enabled HCPF to go back 8 quarters, thereby securing about $19 million for the most recent four quarters, and about $34 million reflecting the four quarters before that. Going forward, the estimate is $19 million additional CHASE annual payout. Additional CHASE monies generated from the Directed Payments work we are now doing in collaboration with the CHASE Board and CHA would create additional funds for FY 2025-26, if approved by the CHASE Board, Medical Services Board and CMS - potentially creating further federal funds drawdowns.

70. **[Rep. Bird] How are HAS fee supplemental payments to hospitals calculated? What is the relationship between the fee pay by a hospital and the supplemental payments they receive?**

RESPONSE

In addition to being limited to no more than 6% of net patient revenues, Medicaid provider fee programs may not hold providers harmless, i.e., a provider fee program cannot have a direct or indirect guarantee that a provider will receive all or a portion of their fees returned in the form of payments. This means providers will not receive Medicaid payments proportional to the provider fees they pay in.

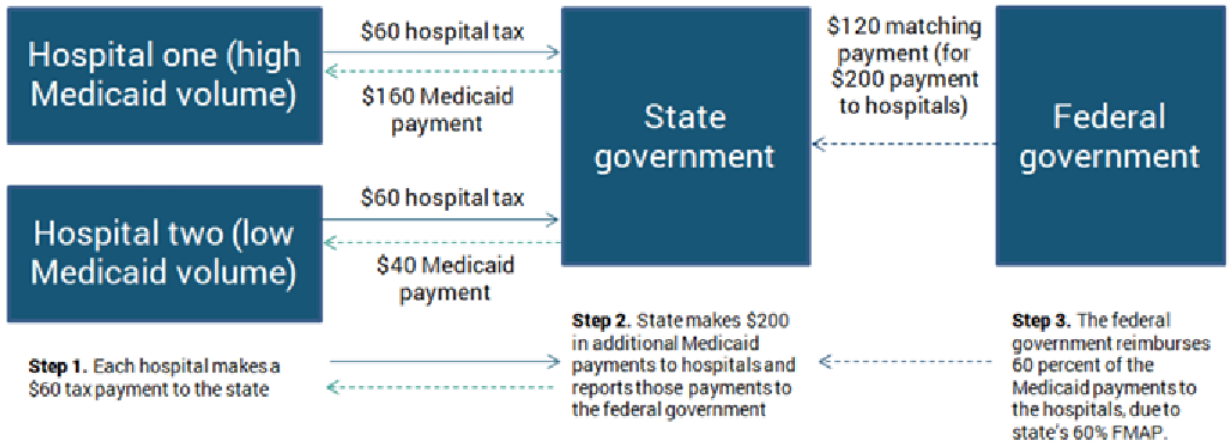
Under federal requirements, provider fees must be assessed on a statistic that applies to all patients. For the HAS fee, we assess fees on total inpatient days and total outpatient charges. While the fees are assessed on all days and charges, the supplemental payments are Medicaid payments and will vary based on the volume of Medicaid patients served. This means some providers could receive Medicaid payments that total more than their fees paid, while others could receive Medicaid payments lower than their fees paid. This is an intentional effect of the federal regulations governing provider fees.

At the same time, because the HAS fee is also used to finance expansions of Colorado's Medicaid and Child Health Plan *Plus* (CHP+) programs, all acute care and Critical Access Hospitals in the state receive claims payments for hospital care provided to these members which would otherwise be uncompensated. In FY 2023-24, approximately 31% of the $3.1 billion in claims paid for Medicaid and CHP+ expansion members was paid to hospitals, or about $968 million.

This graphic from the May 2021 Issue Brief[43] from the Medicaid and CHIP Payment and Access Commission (MACPAC) is illustrative of how provider fees work related to Medicaid supplemental payments:

[43] www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf

FIGURE 2. Illustration of a Permissible Health Care-Related Tax Arrangement for Hospitals with Different Medicaid Volumes



Notes: FMAP is federal medical assistance percentage. This state's FMAP is 60 percent. The above example is illustrative only.

Under the recommendations of the CHASE Board, there are several supplemental payments funded by HAS fees, all of which are approved by the Centers for Medicare and Medicaid Services (CMS) in HCPF's approved Medicaid State Plan. These payments are for inpatient and outpatient services provided to Medicaid members and are based on Medicaid volume and costs, quality performance, and lump sum funding for Colorado's Critical Access Hospitals. The HAS fee also finances Disproportionate Share Hospital (DSH) payments for hospitals who participate in the Colorado Indigent Care Program, are Critical Access Hospitals, or otherwise serve a disproportionately higher volume of care for Medicaid members or uninsured patients.

HAS fees and supplemental Medicaid and DSH payments are detailed in the CHASE Annual Report sent to the Joint Budget Committee, the Senate and House Health and Human Services Committees, and others each Jan. 15.

SAFETY NET AND DENVER HEALTH

71. [Sen. Bridges] The JBC has heard concerns about rural safety net providers closing sites or cutting back services due to Medicaid rates. Please describe the risk. Why are the Medicaid rates so problematic for these providers? What additional measures could the legislature take to support them, including both fiscal and non-fiscal remedies?

RESPONSE

Safety net providers' financial difficulties increase the risk of reduced access to care for patients, especially in rural areas where there are fewer provider options. Medicaid and Medicare, as major payers for rural safety net providers, play a large role in their financial

standing. Plus, with their higher proportions of uninsured patients, efforts to reduce the number of uninsured Coloradans in rural areas are especially helpful for these providers.

Medicaid reimburses Federally Qualified Health Centers (FQHCs) based on the cost of providing care, and Medicaid reimbursement for rural hospitals in aggregate is 96% of their cost of providing care (see Table 1). While this is a favorable aggregate payment rate for rural hospitals and higher than their urban counterparts, the aggregate findings mask the varied outcomes for individual rural hospitals, some of which face very different financial situations. Also, rural safety net providers struggle to cover their full operating costs due to low patient volumes and a higher proportion of patients covered by public payers compared to private payers. According to data sourced in the Colorado rural Health Center's Snapshot of Rural Health in Colorado 2024[44], for rural hospitals, approximately 54% of their patients are covered by public payers or are uninsured and about 46% covered by private insurance. Further, while rural Critical Access Hospitals (CAHs) are paid on a cost basis by Medicare, through sequestration, CAH Medicare reimbursement rates are subject to a 2% reduction through 2032, meaning CAHs are currently paid below cost of care provided to Medicare patients.

HCPF has a number of efforts underway to support rural hospitals and other rural safety net providers including RAE support for rural practices and dedicated Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) funding for rural hospitals:

RAE Support for Rural Practices

In addition to the overall requirements of the Regional Accountable Entities (RAEs) to support providers and provide practice transformation, HCPF has added specific requirements for the RAEs to provide resources and tools to rural providers in ACC Phase III. RAEs must design and implement strategies to enhance the financial and technical support of their contracted providers in rural communities and to complement HCPF's implementation of Senate Bill 22-200 and Senate Bill 23-298. This includes providing shared resources, condition management programming, supporting communication tools and population health analytics to rural providers. RAEs may also fund investments in needed and shared infrastructure and services across rural hospitals and clinics (e.g., care coordination models, software, assistance connecting to and utilizing state HIT systems, etc.). This ACC Phase III attribute is critical to helping rural, independent primary care clinics and rural health clinics obtain the infrastructure that enables them to be in Accountable Care Organization (ACO) partnerships with commercial carriers and Medicare Advantage carriers, in addition to Medicaid, enabling them to earn value-based payments thereby significantly propelling their sustainability; it further helps them drive improved care outcomes, patient quality care and affordability.

To further support rural practices (in addition to pediatric and small practices), HCPF is proposing modifications to integrate aspects of current Alternative Payment Models

[44] coruralhealth.org/snapshot-of-rural-health#/

(APM) with the ACC under a comprehensive primary care payment framework as part of the FY 2025-26 R-6, "Accountable Care Collaborative Phase III." By repurposing the APM 2 rate increase approved in FY 2022-23, HCPF will create a dedicated pool of funds to directly support critical primary care practices, including rural clinics, to maintain access to care for Health First Colorado members in areas where access is under pressure. Rural Primary Care Medical Providers (PCMPs), or those primary care providers both enrolled with Medicaid and contracted with a RAE, that operate in areas with a total geographic population lower than 50,000 and where population density is below 50 individuals per square mile would be eligible to receive these repurposed payments. At this time, there are 115 eligible rural PCMPs (14% of the total PCMPs), which serve 7% of total members.

CHASE Support for Rural Hospitals

Through the CHASE hospital provider fee program, CAHs and other rural hospitals with 25 or fewer beds receive an equal portion of the dedicated funding, which was $26 million in the most recent year resulting in payments of $765,000 to each of 34 qualified hospitals.

In addition, to support CAHs with the lowest financial resources, CHASE includes a $12 million annual payment for each of five years ($60 million total) to 23 CAHs to support their quality of care efforts as part of the Hospital Transformation Program. Each hospital receives $522,000 per year. The Rural Support Program is entering its fourth of five years and $36 million has been paid to date.

In addition, HCPF continues to work to strengthen its relationship with rural and frontier providers to support solution-based discussions to move from reactive to proactive engagement on rural provider issues. Understanding the specific issues faced by rural hospitals and other safety net providers in Colorado will help prioritize efforts in areas that can drive meaningful progress toward sustainability.

In partnership with the Office of eHealth Innovation (OeHI) (in the Lieutenant Governor's Office) HCPF has developed and implemented Rural Sustainability Payments[45]. This program distributes an annual $100,000 payment to Critical Access Hospitals and $20,000 to Certified Rural Health Clinics, contingent on their ongoing participation in OeHI's Rural Connectivity Program. The Rural Connectivity Program has been funded through OeHI, with significant Federal Funding Match through Centers for Medicare and Medicaid Services (CMS), with support from HCPF and the General Assembly through concurrent, approved Capital Construction Funding requests. This program has enabled increased technical connectivity through participation in the state Health Information Exchange (HIE) infrastructure and developed and deployed the Community Analytics Platform which offers real-time analytics to the entire rural community. These efforts improve coordination among health care providers

[45] www.coloradosos.gov/CCR/GenerateRulePdf.do?ruleVersionId=11320&fileName=10%20CCR%202505-10%208.8000

by providing updated patient and population health data across health systems and enabling technology to reduce administrative burden on providers. To date, only 40 of the identified rural facilities for this program remain to be connected.

The General Assembly could take a wide range of measures to increase support for rural safety net providers including increasing payment rates where possible, advocating for federal increased reimbursement, and grant action in rural areas to more targeted action for less financially stable providers. HCPF recognizes the pressure that providers in rural areas face and looks forward to working with the Joint Budget Committee on continued solutions.

Table 1: Payment to Cost Ratio 2023, by Geographic location. Self-reported financial data by hospitals.

Payment to Cost Ratio -2023

Location*	Medicare	Medicaid	Commercial	Self Pay	CICP/ Other	Total
Frontier	0.87	0.96	0.92	0.67	1.10	0.91
Rural	0.74	0.96	1.45	0.89	0.58	1.00
Urban	0.72	0.77	1.67	0.13	0.86	1.00
Grand Total	**0.73**	**0.79**	**1.63**	**0.25**	**0.84**	**1.00**

*County designations are sourced from the Colorado Rural Health Center and available at: https://coruralhealth.org/[46]

72. [Rep. Bird] What is the Department doing to sustain the partnership with Denver Health and ensure that this vital provider continues to be able to provide services for Medicaid clients, since the Department did not request any additional General Fund support.

RESPONSE

HCPF is actively engaging with Denver Health to explore ways to assist and stabilize Denver Health as a vital safety net hospital in the state with support and insights from outside expert consultants. HCPF is engaged with Denver Health to review existing payment methodologies and explore potential additional funding possibilities to increase federal matching funds where possible.

Existing payment methodologies include Denver Health's supplemental payments for its ambulance and physician services and its payment for Medical Assistance Site activities. Potential additional funding opportunities include State Directed Payments to Denver Health Medicaid Choice for its physician services and reviewing the agreement between Denver

[46] coruralhealth.org/

Health Hospital Authority and the City of Denver to determine if there are any opportunities to bring in additional federal matching funds. This includes reviewing the recent passage of Ballot Measure Q2 which will generate an estimated additional $70 million in sales taxes for Denver Health. HCPF in partnership with Denver Health is exploring opportunities to draw additional federal matching funds on these dollars.

In addition to those opportunities, HCPF also met with the Colorado Commission on Family Medicine and learned more about the new residency program at Denver Health Community Services. The Colorado Commission on Family Medicine has requested additional funds to allow for the expansion of their program to include Denver Health. Investment in health care includes investing in the future of the workforce and the funding of a new residency program would be a meaningful investment in the future of Denver Health.

Denver Health is also anticipating some relief with the implementation of Cover all Coloradans when it goes into effect on Jan. 1, 2025. Denver Health has communicated to HCPF that they expect at least 10,000 of their patients to qualify for Cover all Coloradans. They expect that the coverage that will be provided under the expansion will help to pay for uncompensated care in primary care, non-emergent care, and prenatal care.

COVER ALL COLORADANS

73. [Sen. Bridges/Sen. Amabile] Compare the fiscal note assumptions to the Department's November forecast for H.B. 22-1289 (Health benefits for children and pregnant women lacking access due to immigration status), including changes in the expectations for both children and pregnant women. What caused the Department's forecast to change so dramatically?

RESPONSE

The table below shows the utilizers and per capita assumptions used in the fiscal note for HB 22-1289 Cover all Coloradans (CAC) and HCPF's revised forecast for the program:

Medicaid Postpartum and Prenatal Cost			
	Total Cost	**Per Capita**	**Enrollment**
November Forecast	$16,855,510	$7,498.00	2,248
Fiscal Note Estimate	$27,433,944	$12,512.11	2,193
Difference	**($10,578,434)**	**($5,014.11)**	**55**

CHP+ Postpartum and Prenatal Cost			
	Total Cost	**Per Capita**	**Enrollment**
November Forecast	$1,934,629	$8,338.92	232
Fiscal Note Estimate	$2,141,533	$15,284.12	140
Difference	**($206,905)**	**($6,945.20)**	**92**

Non-Citizen Children Medicaid Look-Alike			
	Total Cost	**Per Capita**	**Enrollment**
November Forecast	$14,789,993	$2,551.76	5,796
Fiscal Note Estimate	$2,020,865	$3,607.87	560
Difference	**$12,769,128**	**($1,056.11)**	**5,236**

Non-Citizen Children CHP+ Look-Alike			
	Total Cost	**Per Capita**	**Enrollment**
November Forecast	$17,285,613	$2,551.76	6,774
Fiscal Note Estimate	$2,339,998	$2,983.72	784
Difference	**$14,945,615**	**($431.96)**	**5,990**

Funding for the CAC expansion to children will come from General Fund and will not receive a federal match. Funding for pregnant and postpartum populations will receive a 65% federal match under the Children's Health Insurance Program (CHIP). CHIP has an election that allows for coverage of pregnant people through an amendment to the State Plan. Under CHIP, with administrative dollars known as Health Services Initiative (HSI) funds, the state can pay for post-partum coverage up to 12 months after the end of the pregnancy. The estimates reflect these federal funding sources for the pregnant and post-partum populations.

The primary difference between the fiscal estimate and the 2024 November forecast estimate is the number of utilizers in the children's populations (Medicaid and CHP+ look alike programs). This increase is partially dampened by a true-up of the per capita costs in the pregnant populations based on the per capita costs for the pregnant populations currently enrolled in Medicaid and CHP+. In estimating the number of child and adult utilizers for the 2022 fiscal note, HCPF used data and analysis published by the Colorado Health Institute estimating the number of children who did not have health insurance coverage due to a lack of qualifying immigration status, trended forward by the population growth percentages published by the Colorado State Demographer's Office with an applied take up rate estimated for a similar program in the State of Oregon. Legislative Council Staff agreed with this approach, as did advocates supporting the bill.

When HB 22-1289 was under consideration by the General Assembly, HCPF was aware of the risks associated with generating population and uptake estimates for a group of people that have historically been difficult to accurately count, i.e. foreign born noncitizens who are not legal residents. HCPF engaged with various stakeholders throughout the legislative process and relied on data from the Colorado Health Institute, which has attempted to estimate this population as part of their Colorado Health Access Survey. HCPF also took into consideration the slow uptake of services offered to this population via SB 21-009, "Reproductive Health Care Program," in determining uptake.

During the course of implementation, HCPF revisited the service cost estimate and considered new factors. First, throughout 2023 there were several major waves of new immigrants entering the US. Denver was one of the major destination cities. This could not have been predicted during the legislative consideration of HB22-1289. HCPF sought guidance from several migration and immigration experts as to the demographics of the new arrivals to update the eligible population, including the State Demographer's Office, Governor's Office of New Americans, Denver Health, and the City and County of Denver. Due to the nature of the immigration wave, the lack of coordinated federal action, and the ease of movement between state lines, it was not possible to accurately count the new arrivals nor to realistically understand their demography.

Second, HCPF continues to work closely with the Division of Insurance and is aware of the considerable interest in OmniSalud, an insurance program that allows Coloradans without documentation to enroll in a Colorado Option insurance plan. The waitlist and speed with which the program filled has led HCPF to believe that there is pent-up demand for health care coverage among this population.

Third, HCPF learned from its counterparts in other states, particularly Oregon, that uptake occurred faster than initially anticipated, eligible populations were larger than initially estimated, and utilization patterns were different from similar populations of traditionally eligible citizens.

Finally, HCPF was able to use existing data to update past estimates, specifically, the number of births that occurred within the Emergency Medicaid Services (EMS) benefit, which is the only Medicaid benefit currently available to individuals who lack a qualified immigration status and the number of children lacking a qualified immigration status accessing EMS services.

74. [Sen. Amabile] Please explain the basis for the Department's assumptions about per capita costs and enrollment for the children and pregnant women lacking access due to immigration status.

RESPONSE

Enrollment Assumptions:

Please see HCPF’s response to question 73 for a detailed explanation of the assumptions behind the enrollment projections for children and pregnant women.

Per Capita Cost Assumptions:
HCPF’s process and assumptions in developing the per capita cost estimates for children and pregnant women under HB 22-1289 Cover all Coloradans (CAC) was based upon historical utilization patterns of similar (existing Medicaid) populations and on actuarial analysis.

HCPF's actuarial contractor recommended rates for the various capitated programs administered by HCPF and the RAEs. This includes the capitated Medicaid behavioral health

benefit, CHP+, Rocky Mountain Health Plan, and Denver Health Medical Plan. HCPF used these actuarial estimates to extrapolate the projected per capita costs for the fee-for-service costs, specifically by using the estimated Denver Health Medical Plan capitation rates as a proxy for general Medicaid FFS expenditures in per capita terms. These per capita cost estimates were then compared to historical expenditures for children and pregnant/postpartum populations in HCPF's forecast. The actuarial estimates were mostly in line with expectations, aligning with HCPF's historical expenditure pattern. Therefore, HCPF assumed the expenditures associated with the pregnant and postpartum populations would reflect the per capita costs of the existing pregnant and postpartum populations.

For the non-pregnancy related medical services (services provided to children and post-partum adults), HCPF assumed the per capita expenditures would be slightly lower relative to the similar existing Medicaid populations, based on the assumption that this new population will not use services at the same rate as the existing Medicaid population. This assumption draws from the experience of the State Medicaid Agency in Oregon as well as HCPF's experience with a smaller scale state-only program, e.g. SB 21-009. Given that the per capita costs estimated by the actuarial contractor were similar to the historical expenditure patterns observed within HCPF data and were slightly lower than the per capita costs associated with the existing Medicaid population, HCPF chose to project per capita costs for children and pregnant/postpartum adults using the extrapolated actuarial contractor calculations. These per capita costs are of a similar magnitude to those assumed in the initial fiscal note.

75. [Rep. Sirota] How do changes in immigration policies and trends since 2022, including the November election, impact the Department's projections? Is the November election changing the number of people seeking services? Does the Department expect changes in future years?

RESPONSE

Since the original fiscal projections, Colorado's migrant population has increased. Throughout 2023, there were several waves of new immigrants into the United States and Denver was one of the major destination cities. This migration increase impacted the HB22-1289 enrollment forecast. Please see HCPF's response to question 73 for a detailed breakdown of the updated forecast. Following the November election, stakeholders, including community organizations, advocates and providers expressed concerns about enrolling in the program due to data privacy concerns, immigration enforcement fears, and "public charge" rules. Public charge is an immigration inadmissibility rule that applies to some noncitizens—health care and other services do not currently apply to public charge considerations. Because the program is not yet in effect, it is unclear how the federal election will impact the number of people seeking services. Future changes to the public charge rule and federal immigration policy may impact the willingness of this population to enroll or seek services. During his previous administration, the president-elect made changes to the public charge rule. The incoming administration has also been very vocal about immigration enforcement.

76. [Rep. Sirota] What is the Department doing to ensure pregnant women and the families of children feel safe enrolling in the program?

RESPONSE

HCPF has been very intentional in developing messaging and outreach materials as well as partnering with communities to support the implementation of HB 22-1289 Cover All Coloradans (CAC).

First, we deployed a Community Ambassador Program (CAP), an evidence-based strategy that engages organizations that are trusted local resources in their communities to conduct education and outreach. A key to the community engagement that was required per the bill is that communities are experts in their own lived experiences[47] and partnering with community-based organizations increases program participation and sustainability.[48] [49] The ambassador program model leverages and supports local networks and partners who know and understand the issues facing their communities. This approach improves trust, addresses disproportionate population-level impacts, prevents future health disparities, and lays the foundation for new partnerships.

HCPF utilized a competitive solicitation process to award funding to community organizations to ensure transparency and performance. HCPF partnered with 10 community organizations in its first round of grants and 17 community organizations in its second round of grants. Ambassador organizations are located throughout the state. To date, ambassadors estimate they have reached a total of 69,078 individuals. A total of 1,557 community members received assistance with enrollment support for Emergency Medicaid Services, Health First Colorado and Child Health Plan *Plus* (CHP+). This outreach is conducted through community touchpoint events which ambassadors host 1-2 times per month. Examples of these events are Immigrant and Community Integration events, Health Fairs and Cultural Celebrations, Community Education Sessions, and Community Enrollment Sessions.

Second, HCPF held its own stakeholder process that includes three internal cross departmental presentations and 31 external presentations in 2024. HCPF repeated most of these meetings during the day and evening and provided live Spanish interpretation services. The average attendance ranged from 15-200 attendees. Topics discussed include: Cover All Coloradans Program Review, Cover All Coloradans Program Updates, Community Organization Ambassador Program Overview, and trainings on Health First Colorado and CHP+ benefits and services, identifying eligibility criteria for Cover All Coloradans population and how to use Cover All Coloradans tools and resources effectively. In addition to stakeholder meetings and presentations, HCPF is in regular communication with the community through our Cover All Coloradans newsletter, website and email address.

[47] rootcause.org/field_notes/community-engagement-and-the-expertise-of-lived-experience/
[48] pmc.ncbi.nlm.nih.gov/articles/PMC2837458/
[49] pmc.ncbi.nlm.nih.gov/articles/PMC7537729/#bib0140

Third, HCPF is working with state partners, Division of Insurance and Connect for Health Colorado to ensure coordination across programs, training across networks and development of tools and materials for our various audiences.

Finally, HCPF has been very thoughtful about developing materials that are honest and accessible. We provided ambassadors with a communications toolkit to help ensure they are supported when promoting the program, enrolling members and talking to the media. The toolkit includes key messaging, outreach materials and templates, as well as FAQs. All of our materials are translated in the Spanish and many of our communications materials have been translated into six additional languages and were developed in consultation with stakeholders and translators who understand the complexity and concerns of the audience. HCPF is emphasizing member privacy is important, state employees have obligations to protect the privacy of immigration information under state law, and health care services do not impact public charge.

77. **[Rep. Sirota] Some counties complain about a lack of guidance and training on the implementation of H.B. 22-1289. Please describe the Department's outreach and support to counties. What are the problem areas and what is the Department doing to address them?**

RESPONSE

As part of the overall HB22-1289 project, a comprehensive communications plan and an operational readiness checklist were developed.

As part of the communication plan for the HB 22-1289 Cover All Coloradans (CAC) project, HCPF leveraged multiple existing meetings with different audiences to relay information, guidance and updates about CAC:

- CDHS/County Call, weekly on Wednesdays 8 a.m. - mentioned multiple times
- HCPF/County Directors' Leadership Monthly Call presentations on June 25, 2024 & Oct. 29, 2024
- Metro Human Services Directors' Meeting - attended in person Oct. 24, 2024
- Northwest Human Services Directors' Meeting Nov. 8, 2024
- Discussed at Economic Security Sub-PAC Oct. 3, 2024 & Nov. 7, 2024
- HCPF/Eligibility Site Monthly Touchbase presentations on June 27, 2024, Oct. 24, 2024, Dec. 12, 2024
    - The HCPF/eligibility site monthly touch base meeting is recorded, sent out, and posted to our website for those who are not able to attend. It is sent via CBMS Communication which reaches all CBMS users.

Additionally, the following information was sent out and published:

- CAC Operational Memo posted on Dec. 4, 2024
- One-page CAC fact sheet for county directors sent Dec. 3, 2024
- CBMS October Build Release Oct. 9, 2024, to all CBMS users included the CAC CBMS project

- Stand-alone CAC CBMS training Oct. 8, 2024
    - Counties are encouraged to review CBMS build documentation so that they are educated about upcoming changes.

To date:

- 33 counties have staff who have reviewed the CBMS build training
- 42 counties have staff who have reviewed the stand-alone CAC training

Ongoing support: Counties have several avenues available for ongoing support where they can ask questions and get help which include:

- Medicaid Eligibility Inbox
- CAC Inbox
- Staff Development Division Inbox
- HCPF/Eligibility Site Monthly Touchbase meetings

HCPF is also creating a training specific for county workers on basic cultural competency including basic/broad elements of working with newcomers. Additionally, HCPF is also working on a "special topics" training specifically focused on newcomers.

Problem areas:

The biggest problem HCPF faces is reaching workers. There are about 2,000 eligibility technicians processing medical assistance applications across the state. Information is presented in meetings, sent out via email, posted in memos and web-based trainings, but still, it is challenging to get information to all those who need it.

Specifically:

- Not all counties have representation at the identified meetings.
- Not all county workers review the CBMS Build Notes.
- Not all county workers review available training.
    - The CAC training was not required. HCPF does not have resources needed to track and enforce compliance when requiring trainings.
- Not all counties have processes in place to disseminate information to all eligibility workers.
- Not all county workers read CBMS Communications or Operational Memos.
- At this time, HCPF has not mandated the completion of the training, but can make it a requirement in early 2025 if counties continue to report resources are not available. The participant data shows that not all counties have accessed the resources HCPF has provided.

In addition, counties are not required to participate in every state training; therefore, HCPF strongly encourages them to take the trainings for any new program including implementation of 22-1289. HCPF is revising its county administration rules in partnership with counties, advocates, providers and other community partners in 2025 to further clarify training, staffing and other opportunity areas to improve administration of our programs.

78. [Rep. Bird] What Medicaid and public health (through CDPHE) services are these populations eligible to receive without the new benefits and how much do we pay for those services? Do we expect changes in those expenditures if we proceed with the new benefits?

RESPONSE

Through Medicaid, the children and pregnant people who will be served by HB 22-1289 Cover all Coloradans (CAC) are currently eligible to receive limited benefits and services, including Emergency Medicaid Services (EMS) and Family Planning Services, as appropriate. These are available to individuals who would meet income and general eligibility requirements for Medicaid except for immigration status (not only pregnant people and children). Neither of these programs, or programs offered through the Department of Public Health and Environment (CDPHE), provide access to comprehensive preventive health care services or health coverage. These populations can also access some services through Federally Qualified Health Centers, safety net clinics, and charity care.

HCPF is seeking federal approval to cover labor and delivery for the new population at the enhanced 65% Children's Health Insurance Program (CHIP) match rate. Under federal CHIP law, states may elect to cover prenatal care, labor and delivery, and postpartum care for pregnant and postpartum people regardless of immigration status. Besides altering the federal match on services, increasing access to routine care that is included under the HB22-1289 Cover all Coloradans (CAC) expansion shifts costs from high-cost emergency services to low-cost preventive care. This is especially salient for prenatal care, which has shown reductions in Cesarean section rates, expensive NICU stays and other maternal-infant emergencies. This impacts costs associated with both the birthing parent and the infant.

The EMS benefit covers treatment of emergency medical conditions—including labor and delivery—with 50% federal match. Annual expenditure for EMS in the last year was $95.3 million and for pregnancy and childbirth specifically was $23.4 million. The EMS benefit is limited to "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: Placing the patient's health in serious jeopardy; Serious impairment to bodily function, or Serious dysfunction of any bodily organ or part." (42 U.S.C. § 1396b(v)(3); Colorado Revised Statutes § 24-76.5-102(1); and 10 CCR 2505-10, § 8.100.3.G.1.g.viii).

The Family Planning Services benefit provides access to birth control options for men and women including vasectomies, condoms, birth control pills and IUDs. This program launched in July 2021, and early expenditures remain below original projections. In FY 2023-24, 4,206 people accessed services and HCPF spent $1,406,632 on an incurred basis. The Family Planning program is funded through state dollars, so for individuals who are eligible for CAC and federal match (pregnant people through 12 months postpartum), we would now be able to draw federal match on this statutorily required program.

These populations may also receive services through hospitals' charity care programs, through Federally Qualified Health Centers (FQHCs) and safety net clinics. When undocumented

individuals receive care from hospitals that is not reimbursable through EMS or Family Planning benefits, the hospital will count those costs toward uncompensated care. FQHCs serve medically underserved areas and populations. FQHCs are required to care for uninsured patients regardless of a patient's ability to pay. Services are provided on a sliding scale fee based on a patient's ability to pay. FQHCs have historically and will continue to provide services to undocumented individuals, but it will impact their sustainability. Safety net clinics also provide primary and dental care services to low-income and marginalized communities. They are generally funded through grants and donations.

Through other public health programming at CDPHE, individuals without documentation in the state are eligible to receive benefits through Title X Family Planning Programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Care Coordination for Children and Youth with Special Health Care Needs, Vaccines for Children (VFC) and the Women's Wellness Program (Breast and Cervical Cancer Screening). These programs either do not ask for citizenship status or are prohibited from asking about citizenship status; therefore, it is impossible to estimate the cost of providing services to this population. HCPF has not previously calculated changes in Medicaid expenditures for these programs as they are outside of our scope and the population impact is unknown. The state will continue to incur cost of care for these individuals, and investment in low-cost preventive services remains the most effective way to reduce reliance on high-cost emergency Medicaid services.

PROVIDER PAYMENT

79. [Sen. Amabile] How much do providers spend on uncompensated or undercompensated care for these populations?

RESPONSE

HCPF has information on hospitals' uncompensated care costs in total, but does not have such information by patient type, such as children and pregnant persons, nor do we have this information discretely for patients who lack documentation of lawful presence in the U.S.

Most reporting on the uncompensated and undercompensated care costs for immigrants focuses on the adult or total population and may not directly correlate to the population that would be covered under Colorado HB 22-1289. In reviewing reported costs for the total or adult population, the Kaiser Family Foundation reports lawfully present and undocumented immigrants use less health care than U.S.-born citizens. In 2021, the average annual per capita expenditure for all immigrants, lawfully present and undocumented, was about two-thirds of the expenditure for U.S.-born citizens, an average of $4,875 for immigrants and $7,277 for U.S.-born citizens (www.kff.org/racial-equity-and-health-policy/issue-brief/immigrants-have-lower-health-care-expenditures-than-their-u-s-born-counterparts/).

More recently, Denver Health reported approximately $10 million of their total $130 million in uncompensated costs for 2023 was attributed to care for the migrant population, but that number is not restricted to the population that would be covered under HB 22-1289.

coloradosun.com/2024/03/13/denver-migrants-immigration/

80. [Rep. Bird/Sen. Amabile] What are the impacts on people and providers if we pause or cap the new benefits?

RESPONSE

Pausing or capping the new benefits will have significant impact on the health outcomes of people living in Colorado and financial impacts on providers who serve the state's most vulnerable.

Impact on People

The new benefits under HB 22-1289 Cover All Coloradans (CAC) are targeted to pregnant people and children—two populations for whom the U.S. health care system has established that investments in preventive, low-cost care have high returns on investment. Inadequate prenatal care has been associated with myriad negative outcomes including increased risk of prematurity and infant death.[50] For example, pregnant people who have not received prenatal care are more likely to have a baby admitted for expensive NICU stays (11.1% versus 5.2%),[51] and in a state where the maternal mortality rate continues to increase at an alarming rate,[52] the stakes are high. For children, investments in early intervention and primary care have been shown to reduce ER admissions, improve school performance and increase vaccination rates.[53] Additionally, these individuals will remain eligible for Emergency Medicaid Services (EMS), which include costly ER visits and more complicated (and expensive) labor and delivery costs, some of which could be preventable through preventive, primary care services available in the Cover All Coloradans benefit package.

Besides the impact on the health and cost of care for these individuals, there is also the likelihood for increased mistrust and confusion in immigrant communities after broad outreach for program enrollment. HCPF has conducted extensive outreach to providers, partners and Colorado residents to make sure children and families are aware of the benefit and signing up for coverage starting Jan. 1, 2025. HCPF alongside Connect for Health Colorado strongly encouraged pregnant people and children to enroll in Medicaid/CHP+ and bypass their opportunity to enroll in OmniSalud for coverage in 2025. If the program were paused or capped, pregnant people and children eligible for OmniSalud would go without coverage due to HCPF guidance. OmniSalud is a capped program and met its enrollment cap within days.

Impact on Providers

Enrolling individuals into the CAC expansion means that children and pregnant people will have a source of health coverage and a payer for their health benefits and services. Coverage encourages a more efficient pattern of utilization and ultimately reduces costs for the

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[50] https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/reports/final-recommendations.pdf

[51] https://www.tandfonline.com/doi/abs/10.3109/14767059609025415

[52] https://drive.google.com/file/d/1L8YyFzO7MUKJuG17p2qa1O8mwTz_PR4T/view

[53] https://www.urban.org/research/publication/how-do-children-and-society-benefit-public-investments-children

system. If the CAC expansion were paused or capped, providers who serve this population will lose a new source of revenue, but continue to see these individuals in their clinics and emergency rooms. This is inefficient and costly care and does not provide the right care that people need to keep being productive members of our community at work and at school. Instead of shifting state investment into low-cost preventive services, we are more likely to see continued utilization of high-cost emergency services in hospitals and high numbers of uninsured patients presenting at safety net clinics and Federally Qualified Health Centers (FQHCs).

For hospitals, Denver Health (DH) alone makes up 26.0% of all total uncompensated care costs in the state. When looking at charity care costs, Denver Health makes up approximately 79.4% of charity care costs for independent hospitals, more charity care costs than any statewide system. Denver Health took on the brunt of the migrant crisis health care load spending $10 million caring for migrants in just three months. Through coverage offered under the CAC expansion, DH will be able to ensure that, as an alternative to high-cost emergency care, its patients are seen in a low-cost primary care setting and receive lower cost preventive services. Denver Health already has the highest number of CAC enrollees since HCPF began running eligibility in November 2024.[54]

UCHealth, which includes hospitals in Aurora, Greeley and Colorado Springs, estimated it spent about $17 million on uncompensated care for migrants in a three-month span.

FQHCs serve medically underserved areas and populations. FQHCs are required to provide care to uninsured patients regardless of a patient's ability to pay. Services are provided on a sliding scale fee based on a patient's ability to pay. FQHCs have historically and will continue to provide services to undocumented individuals, but it will impact their sustainability.

Similarly, safety net providers agree to serve people whether they are covered or not. However, the donations and foundation grants that safety net clinics use to fund their operations are declining. Most clinics have cut back services to stay open, but that means fewer opportunities to get care at a less costly level and increased emergency room use, which is very costly and leads to worse health outcomes for members. For those safety net clinics who bill Medicaid, CAC represents the possibility of some financial relief in return for serving this population.

ALL PAYER CLAIMS DATABASE

81. [Rep. Sirota] What are the data security needs of the APCD? Is the Department submitting a supplemental request? If not, how will the APCD address these needs?

RESPONSE

The Center for Improving Value in Health Care (CIVHC) has had the same data vendor for over 8 years. During that time, the foundational data architecture of the APCD has remained

[54] https://coloradosun.com/2024/03/13/denver-migrants-immigration/

essentially the same. Security protocols, data intake processing, data release mechanisms, analytic tools, and storage capabilities are based on the same data architecture as when CIVHC initially contracted with the current data management team in 2016. Since that time, technology has significantly advanced, particularly in big data management and manipulation, and security risks have become more numerous and sophisticated. The APCD has strong cyber-security, but no matter how well managed, the existing system cannot keep pace with the increasing sophistication of current cyber-attacks. The APCD relies on IT infrastructure that was not designed to protect against current cyber-security risks and lacks adequate resources to update network security and compliance, causing sub-optimal performance, increased operations costs, and potential serious security and compliance risks.

With over 17 terabytes (TB) of sensitive data, the APCD relies on high-performing information technology (IT) infrastructure and security protocols to efficiently manage and safeguard the system. Every year, an additional 1-2TB of new claims are added and dozens of releases of data and reports are processed. In FY 2023-24, CIVHC released 25 public analyses using APCD data and provided 81 non-public releases of APCD data to 43 different organizations. With such a high volume and rate of exchange of Personal Health Information (PHI), the APCD must ensure compliance with complex data privacy laws such as the federal Health Insurance Portability and Accountability Act (HIPAA), ensure organizations receiving data are compliant with CIVHC's Data Use Agreement (DUA) and data destruction policies, and protect against increasingly sophisticated network security threats and phishing schemes.

The complexity of the APCD's security and compliance environment has grown substantially as the volume of claims, the number of insurers data submitters, and the number of data releases have grown. Health data is increasingly targeted by hackers attempting to hold stolen data ransom for high dollar payouts and who use sophisticated phishing schemes and other forms of social engineering. Additionally, health data is subject to constantly evolving legal and regulatory requirements at the state and federal levels, which can carry severe financial penalties if violated. CIVHC is increasingly reliant on reactive rather than proactive measures to address these issues, putting the APCD at risk of severe legal consequences, financial penalties, and loss of public trust. A recent security audit of the APCD performed by the Governor's Office of Information Technology (OIT) at the request of HCPF determined that while CIVHC's security measures for the APCD are sufficient for now, there is a need for additional key infrastructure positions and capabilities to ensure APCD security into the future. Addressing these vulnerabilities is especially important as a new data management system is implemented and processes and data are migrated from the old system to the new system.

HCPF submitted a supplemental request to the JBC on Jan. 2, 2025, to increase the funding to CIVHC to address these vulnerabilities specifically. The cost of network security and compliance and data management system re-procurement is $490,472 total funds, including $360,178 General Fund in FY 2024-25, and $4,755,815 total funds, including $2,430,732 General Fund in FY 2025-26. HCPF assumes CMS will approve 33% of the total cost to be funded by Medicaid and 67% to be funded by state-only funding. HCPF assumes the Medicaid portion would receive a 75% federal match rate (matched with General Fund) and the state-only portion would be funded entirely by General Fund. Assuming no additional General Fund

is available, HCPF will work with CIVHC to use their existing General Fund appropriation to draw federal Medicaid funds to assist CIVHC to fund the data security needs and fund the vendor transition. The balance of the costs of the vendor transition and security enhancements will be paid for by CIVHC through the spending of their reserves.

82. [Sen. Amabile] How much does it cost to operate the All Payer Claims Database (APCD)? Where does the APCD get the money?

RESPONSE

The Colorado All Payer Claims Database (APCD) is the state's most comprehensive source of health care insurance claims information representing the majority of covered lives in the state across commercial health insurance plans, Medicare (Fee-for-Service and Advantage), Health First Colorado (Colorado's Medicaid program) and Child Health Plan *Plus* plans. The operating cost of the APCD was $9,451,869 in FY 2023-24. The primary source of funding for the APCD is through the state appropriations set through the budget process and legislative fiscal notes from the General Assembly. The FY 2024-25 General Fund appropriation for the APCD, including the $500,000 scholarship funds, is $4,471,011. Ninety percent of APCD operating costs are covered through state and federal funds. The remaining 10% plus the balance of the budget for the Center for Improving Value in Health Care (CIVHC) comes through licensing fees to non-state entities for data sets, custom report development, and program evaluation.

The scholarships funds are paid to CIVHC to help various entities including state departments, members of the Colorado General Assembly, and not-for-profit organizations with limited resources access APCD data for projects to improve the lives of Coloradans. The fund started in 2014 and has supported almost 200 projects from every health care sector for six years.

HCPF works with the Centers for Medicare and Medicaid Services (CMS) to provide federal Medicaid matching funds for the APCD, but CMS is not willing to match all the state funds or fund the entire cost of the APCD since the work of the APCD is not entirely Medicaid focused. Therefore, over the years, HCPF has developed several financing models to maximize the federal Medicaid match for the APCD. CMS approved a cost allocation formula that allowed HCPF to fund the Medicaid portion (approximately 33%) of the APCD operations at a 50% federal match. This funding supports a portion of general maintenance and operation of the APCD. Additionally, enhanced federal funding (90% or 75% federal funds) supports the implementation of additional initiatives with CIVHC and the APCD that directly benefit the state's Medicaid program. This includes the APCD Data Mart for HCPF's and the Division of Insurance's (DOI) analysts to directly access de-identified data and various reports to support HCPF and DOI analytics. The work that is funded through General Fund only covers mandated public reporting and a portion of general maintenance and operation of the APCD, such as data submitter engagement and data user support. Other revenue sources not provided through HCPF include the licensing fees from providing data and analytics to non-state entities (e.g., universities, health systems, providers, and other entities for research purposes) and private grants.

The table below comes from CIVHC's most recent financial reporting and HCPF's payments.

FY 2023-2024			
Description	Total Funds	General Fund	Federal Funds
General Fund Only Payment	$1,578,262	$1,578,262	$0
Colorado General Assembly Funding though Fiscal Notes	$56,852	$56,852	$0
APCD Scholarship	$498,313	$498,313	$0
Direct Analytics Contract (50/50)	$255,552	$127,776	$127,776
HCPF Cost Allocation (50/50)	$3,240,644	$1,620,322	$1,620,322
Enhanced Funded Projects (90/10 or 75/25)	$2,970,501	$510,995	$2,459,506
Total Funds	$8,600,124	$4,392,520	$4,207,604
APCD Total Costs as Reported by CIVHC	$9,451,869		

R8 COLORADO MEDICAID ENTERPRISE SYSTEMS

83. [Sen. Bridges] What does the Joint Technology Committee (JTC) say about this proposal? If the Department has not presented it to the JTC, please do so.

RESPONSE

HCPF presented an overview of the FY 2025-26 R-8, "Colorado Medicaid Enterprise System Administration," to the Joint Technology Committee (JTC) on Monday, Dec. 16, 2024. The JTC had approved the procurement approach in past legislative sessions so the concept of each of the required pieces of the request was not new to the JTC.

After the overview, a committee member asked what would happen if the request was not funded. HCPF responded that we are required to do the request to qualify for our federal matching funds and clarified that this request is focused on properly staffing the transition which impacts vendor oversight, testing and remediation of technical or other issues identified during testing prior to going live with the new systems. Many of the vendors selected for the current request components are returning, which reduces the risk of transition impacts. The JTC did not raise additional questions related to the request.

84. [Rep. Taggart] Why jump from 3 to 16 modules for the Department's information technology systems? Could we do a smaller change in the number of modules to reduce the complexity?

RESPONSE:

As a result of state and federally mandated procurement requirements, HCPF increased the number of separate operational modules; however, the procurements resulted in only five new vendors that were selected to perform functionality that already existed in the Colorado Medicaid Enterprise.

In 2015, the Centers for Medicare and Medicaid Services (CMS) published a Final Rule requiring modular procurement to receive enhanced matching funds. Under the revised rule 42 CFR part 33, CMS requires states to follow a modular approach for its Medicaid Enterprise Solutions. A module is a discreet, scalable, reusable (across states) system component. In 2022, the Joint Technology Committee approved the capital request for the Design, Development, and Implementation of the procurement.

HCPF is not changing vendors for the core MMIS claims processing and payment module, the Third Party Liability module, the Claims Editing Intelligence module, the CMS interoperability and Patient Access final rule module, or the Prescriber Tool module. HCPF contracted directly with the Electronic Visit Verification Vendor and Care and Case Management vendor, removing the middleman subcontracting relationship as a result of the procurement. HCPF has hired a new Data Warehouse vendor; however, this module was procured as a system takeover, which ensured the same HCPF analytics, reporting, and data structures are maintained. HCPF only has five new vendors for functionality that already exists in the Medicaid Enterprise, including the Electronic Data Interchange, the Provider Call Center, the PBM, Program Integrity and Recoveries (two separate modules, however, the same vendor was awarded the contract for both).

Transition Summary: What Is and Is Not Changing

No Change in Any Way	Recontracted directly. Same vendor. No Middleman.	New Data Warehouse Vendor. Same HCPF Analytics, People & Reporting Tools	Replacing Current Vendor to Deliver Functionality.
• Base/Core MMIS Claims Processing and Payment system (iC) • Third Party Liability Medicaid is "last payer" • Claims Editing-Intelligence software • CMS Interoperability and Patient Access Final Rule • Prescriber Tool - Opioid Module	• Electronic Visit Verification • Care and Case Management System	• Enterprise Data Warehouse for the Business Intelligence Data Mngt System (BIDM)	• Electronic Data Interchange • Provider Call Center • Program Integrity and • Recoveries Electronic Database (same vendor) • PBMS, Rebates & Preferred Drug List, Prescriber Tool - Real Time Benefit Tool

COMMON QUESTIONS FOR DISCUSSION

1. **Please describe one-time state and federal stimulus funds that have been allocated to the Department but are not expended as of September 30, 2023, by bill, budget action, executive action, or other source that allocated funds. The description should include but are not limited to funds that originate from one-time or term-limited General Fund or federal funds originating from the American Rescue Plan Act (ARPA)/State and Local Fiscal Recovery Funds/Revenue Loss Restoration Cash Fund. Please describe the Department's plan to obligate or expend all allocated funds that originate from ARPA by December 2024.**

   Please further describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information: Original fund source (General Fund, ARPA, other), amount, and FTE;

a. **Original program time frame;**

b. **Original authorization (budget decision, legislation, other);**

c. **Requested ongoing fund source, amount, and FTE; and**

d. **Requested time frame (one-time extension or ongoing).**

RESPONSE

HCPF has received the following one-time state and federal stimulus funds that have not been fully expended by Sept. 30, 2023[55]:

- American Rescue Plan Act Section 9817 Home and Community Based Services: This provision in ARPA provided a 10-percentage point increase in the federal match rate for certain Medicaid services for one year, with the requirement to use the freed-up state funds to enhance, expand, and strengthen home and community-based services. Per SB 21-286, the freed-up state funds were transferred to the Home and Community Based Services Improvement Fund to use as the state share for projects implemented through the spending plan, many of which also receive Medicaid federal financial participation (FFP).
- State and Local Fiscal Recovery Fund
    - HB 22-1302 "Primary Care and Behavioral Health Statewide Integration Grant Program": This is a program administered by HCPF to provide grants to physical and behavioral health care providers for implementation of evidence-based clinical integration care models.
    - SB 22-200 "Rural Provider Stimulus Grant Program": This is a program administered by HCPF to provide grants to qualified rural health care providers to improve health care services in rural communities through modernization of information technology infrastructure and expanded access to health care.
    - Vaccine Analyst: HCPF has an interagency agreement with the Governor's Office to fund one FTE to support vaccine outreach. Utilizing SLFRF to support the position, the FTE is responsible for leading the effort to increase the number of Medicaid members fully immunized for COVID-19 and other critical vaccines. The position is funded through June 2024.

The spending for these stimulus funds is in various states of progress. The ARPA HCBS stimulus funds expire March 31, 2025, per guidance from the Centers for Medicare & Medicaid Services. HCPF submits a quarterly report to the JBC describing how HCPF intends to fully expend this funding. The Healthcare Practice Transformation & Integration grant program funding must be obligated by Dec. 31, 2024, with grantees spending of that funding by Dec. 31, 2026. HCPF is currently setting up the grant agreements that will be fully encumbered by

[55] For a complete list of all funds received, see the spending breakdown: https://coforward.colorado.gov/data/agency-spending-data/dept-of-health-care-policy-financing-hcpf

Dec. 31, 2023. The Rural Provider Stimulus Grant Program is currently funded through July 1, 2024, and HCPF is requesting to extend the deadline until Dec. 31, 2024, to expend or encumber the funding. HCPF has adopted program guidelines, including grant application procedures, timelines, eligibility, funding amounts and reporting requirements. HCPF is currently setting up grant agreements with awardees, with seven of 24 agreements fully executed, eight in final approval stages, and drafting underway with nine awardees. HCPF communicates with all awardees regularly.

The following table shows the total stimulus funding, amount spent as of Sept. 30, 2023, the amount remaining per program, the total FTE allocated, and a summary narrative of the spending plan.

COMMON QUESTIONS (WRITTEN ONLY)

Question

1. Please describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information: a. Original fund source (General Fund, ARPA, other), amount, and FTE;
b. Original program time frame;
c. Original authorization (budget decision, legislation, other);
d. Requested ongoing fund source, amount, and FTE; and
e. Requested time frame (one-time extension or ongoing).

RESPONSE

HCPF's FY 2025-26 budget request only included one initiative to replace one-time General Fund or ARPA-funded programs with ongoing appropriations:

- In the R-11 "OCL Benefits" request, HCPF requests to permanently extend the Complementary and Integrated Health Services (CIH) waiver. The waiver provides acupuncture, chiropractic, and massage therapy to members with qualifying conditions such as a spinal cord injury; it also provides many other waiver services, such as personal care and respite. The waiver is described in statute as a pilot program to provide complementary and alternative medicine to qualifying members and has an expiration date of September 2025. HCPF believes that continuing to provide access to these vital services has broad support among members, stakeholders, and providers, as it did when the waiver was expanded in 2021 through SB 21-038. The waiver is funded through General Fund and federal funds and administered by 2.0 FTE. It was originally authorized under HB 09-1047, extended through SB 19-197, and expanded through SB 21-038. HCPF is requesting to continue the waiver ongoing, including the 2.0 FTE to administer it, using General Fund and federal funds. HCPF's request to continue the CIH waiver includes an increase of $73,133 total funds, including $36,567 General Fund and 1.0 FTE in FY 2024-25, and an increase of $2,561,312 total funds, including an increase of $1,280,656 General Fund and 2.0 FTE in FY 2025-26 and ongoing. These

funds are offset by a corresponding negative annualization in HCPF's FY 2025-26 base budget for a net impact of $0.

In drafting and implementing ARPA programs, HCPF understood that these funds were intended for one-time use and were particularly intentional about not creating funding cliffs. The requests below leverage the learnings from HCPF's ARPA-funded programs and, in particular, identify those opportunities for improved policy and programs, and if possible, that also result in cost savings:

- In the R-11 "OCL Benefits" request, HCPF requests ongoing funding to create a second, higher tiered rate for Alternative Care Facilities (ACFs), which will incentivize ACFs to accept and keep members with higher needs. This was informed by research completed with funding from the Home and Community-Based Services (HCBS) ARPA spending plan on developing a tiered rate methodology for setting levels, with an emphasis on secured settings, for the ACF benefit. This initiative provided insight into how HCPF could create multiple level settings for the ACF program that would limit placement into a skilled nursing facility. The request for the higher tiered rate is ongoing and would be funded with General Fund and federal funds. HCPF's request for a new tiered rate includes a reduction of $717,626 total funds including a reduction of $358,813 General Fund in FY 2025-26 and ongoing. HCPF's request results in a reduction due to savings from members receiving care in a lower cost setting. Currently, members receive care either in a hospital or nursing facility setting if requiring this higher level of care.
- In the R-11 "OCL Benefits" request, HCPF requests to implement a new rate structure for the Job Coaching service that increases employment outcomes for members. In developing this policy proposal, HCPF leveraged the research from the Supported Employment Pilot Program, which was extended and expanded using funds from the HCBS ARPA spending plan. This included determining if expanding incentive-based payments for Supported Employment services within the waivers is cost effective and produces positive outcomes. The request for the new rate structure is ongoing and would be funded with General Fund and federal funds. HCPF's request for a new Supported Employment rate structure includes an increase of $350,000 total funds including $35,000 General Fund in FY 2025-26, a reduction of $1,019,166 total funds including a reduction of $509,583 General Fund in FY 2026-27, and a reduction of $2,038,082 total funds including a reduction of $1,019,041 General Fund in FY 2027-29 and ongoing. HCPF anticipates a reduction over time as members move away from a fee for service model to a model that pays providers based on members maintaining a job with more independence.
- In the R-12 "Integrated Care Benefit" request, HCPF requests to move the first 6 short-term behavioral health visits from HCPF's fee-for-service benefit to the behavioral health capitation program, implement new Health and Behavioral Assessment and Intervention (HBAI) codes, and implement the Collaborative Care Model (CoCM) under HCPF's fee for service benefit for primary care doctors to utilize.

These changes are based on stakeholder feedback gathered through the work under HB 22-1302, "Health-care Practice Transformation," which included grants and technical assistance funded through State and Local Fiscal Recovery Funds. The requested changes to the behavioral health benefit would be ongoing and would be funded with General Fund, cash funds, and federal funds. HCPF's request for implementing these changes for Integrated Care Benefits includes an increase of $1,575,367 total funds including $368,179 General Fund and $117,691 from cash funds in FY 2025-26 and ongoing.

2. **Provide a list of any legislation with a fiscal impact that the Department has: (a) not implemented, (b) partially implemented, or (c) missed statutory deadlines. Please specifically describe the implementation of ongoing funding established through legislation in the last two legislative sessions. Explain why the Department has not implemented, has only partially implemented, or has missed deadlines for the legislation on this list. Please explain any problems the Department is having implementing any legislation and any suggestions you have to modify legislation.**

RESPONSE

Total HCPF-Related Bills 2008-2024: 485

Not Fully Implemented Bills with a HCPF Fiscal Impact 2008-2024: 5

The Department of Health Care Policy and Financing (HCPF) has records of the status of implementation for legislation dating back to 2008. Over the last 16 years, HCPF has successfully implemented over 342 bills. Since Medicaid is governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that require federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval, which was denied. Without federal financial participation, HCPF was unable to implement these bills.

All legislation passed in the last two years—in the 2023 and 2024 legislation sessions—has either been successfully implemented or is on track for a timely implementation.

Bills Not Implemented

Legislation	Legislation Summary	Barriers to Implementation
SB 19-005 Import Prescription Drugs from Canada	This bill creates a new program in HCPF called the Canadian Prescription Drug Importation	The Importation Program, SB 19-005, has been in the implementation phase since 2019. Based on statute, it was estimated that the program would be operational by December 2020 with the first annual report for 2021 reporting on savings

(Rodriquez, Ginal/Jaquez Lewis)	Program. Under the bill, HCPF must submit a federal waiver application to legally import prescription drugs from Canada. Once approved, HCPF will work to design a safe and affordable system to import quality medications at a lower cost for all Coloradans.	achieved through the program. Due to reliance on the federal rulemaking process and the need for federal approval, the program continues to be in the developmental stage. Supply chain partners were identified in mid-2022 and HCPF submitted a formal application to the federal government in December 2022. During 2024, HCPF updated its application twice—once in response to a 2023 FDA request for information and another to address and administrative change. HCPF awaits federal approval.
SB19-235 Automatic Voter Registration Fenberg, Danielson/Esgar, Mullica)	This bill requires HCPF to transfer records of electors who apply for Medicaid to the Secretary of State, subject to compliance with federals laws and regulations, to assist with an automatic registration to vote. The elector would have the ability to decline registration or further detail their registration by affiliating with a party, etc.	For HCPF to implement SB19-235, two federal partners – the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) – are needed to provide HCPF with permission to use certain data feeds and types needed for the voter registration process. CMS provided updated guidance in 2024 for the first time, opening the door to CMS potentially approving a specific plan for automated voter registration. The SSA – which in relevant part provides immigration status data, which would be needed for voter registration – has not indicated that it will allow Colorado to use this data for anything other than determination of eligibility for Medicaid. HCPF leadership along with the Governor's Office have engaged with CMS to help in getting SSA approval but there is not consensus yet.
SB 16-120 Review by Medicaid Client for Billing Fraud (Roberts/Coram)	The bill requires HCPF to provide explanation of benefits (EOB) statements to Medicaid members beginning July 1, 2017. The EOB statements must be	The SB 16-120 project is on hold due to COVID-19, implementation of legislative bills, and audits that need to be implemented next year in the eligibility system. SB 16-120 continues to remain on hold while further assessment and evaluation is conducted. The Program Eligibility Application Kit (PEAK) portal's

	distributed at least once every two months and HCPF may determine the most cost-effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only. The bill specifies the information to be included in the EOB statements, including the name of the member receiving services, the name of the service providers, a description of the service provided, the billing code for the service and the date of the service.	account access and management is at the head of household level and not the individual member level. To maintain member privacy, PEAK would require significant changes to allow individual level access. HCPF continues to explore feasible opportunities to grant individual level access to member claims data, which include but are not limited to, new requirements for Blue Button and the reprocurement of the Colorado Benefits Management System (CBMS).
HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.	HCPF has not yet implemented HB 15-1318, a fully consolidated Intellectual and Developmental Disabilities (IDD) waiver. HCPF's actuarial findings from this work reveal a significant fiscal impact of a redesigned consolidated waiver for which there was no appropriation. Because of this fiscal impact and the lack of ongoing direct service funding associated with HB 15-1318 to implement this mandate, HCPF is taking steps to move the work forward with smaller, incremental changes that will provide a better and more thoughtful experience for members receiving services.

SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	HCPF cannot implement this bill as written because it is contingent upon federal financial participation. In order for the state to receive federal financial participation, hospice providers must bill for all services and 'passthrough' the room-and-board payment to the nursing facility. CMS has indicated to HCPF that there is no mechanism through State Plan or waiver to reimburse class I nursing facilities directly for room-and board, or to pay a provider licensed as a hospice as if they were a licensed class I nursing facility. Although licensed inpatient hospice facilities are a hospice provider type recognized by the Colorado Department of Public Health & Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.

3. **Describe General Fund appropriation reductions made in the Department for budget balancing purposes in 2020, and whether the appropriation has been restored with General Fund or another fund source through budget actions or legislation.**

RESPONSE

- Increase in Member Co-pays: Increased co-pays for many services to the federal maximum, which would result in lower overall payments to providers and save $4.4 million total funds, including $1.0 million General Fund, in FY 2020-21 and $8.8 million total funds, including $2.1 million General Fund, in FY 2024-25 and ongoing. HCPF was not able to implement this initiative in FY 2020-21 due to a prohibition on decreasing benefits during the public health emergency. The FY 2021-22 long bill included funding to undo the increase in co-pays. In FY 2022-23, HCPF requested to eliminate all member co-pays except for those on non-emergent utilization of the emergency room, which was approved as requested.
- Reduction in Senior Dental Program: A decrease of $1.0 million General Fund for services provided through the senior dental program. The funding was fully restored in the FY 2021-22 long bill.

- Reduction in PACE Rates: A 2.37% reduction to rates for the Program for All Inclusive Care for the Elderly in FY 2020-21, which was expected to save $5.9 million total funds, including $2.8 million General Fund. This reduction was one time in nature. The rates reverted to normal growth in FY 2021-22.
- Reduction in Teaching Hospital Supplemental Payment: A decrease of $4.4 million total funds, including $1.9 million General Fund, to eliminate supplemental payments to Denver Health and the University of Colorado for graduate medical education. The funding attributable to the Family Medicine program of $1.2 million was restored in FY 2020-21 and subsequently combined into the Family Medicine line item in FY 2021-22. The remaining funding was not restored.
- Reduction in Pediatric Hospital Supplemental Payment: A decrease of $2.7 million total funds, including $1.3 million General Fund, to reduce this supplemental payment to Children's Hospital by 20%. This funding was restored in the FY 2024-25 long bill.
- Reduction to APCD Scholarship Program and State Support: A decrease of $1.2 million General Fund for eliminating a $500,000 grant program that offset access costs for qualifying applicants and reducing state-only support. This funding was restored in the FY 2022-23 long bill.
- HB 20-1361 Adult Dental Cap Reduction: Reduced the adult dental benefit cap from $1,500 to $1,000 per recipient per year, which reduced appropriations by $5.2 million total funds, including $1.1 million General Fund, in FY 2020-21 and $11.1 million total funds, including $2.3 million General Fund, in FY 2021-22. HCPF was not able to implement this initiative in FY 2020-21 due to a prohibition on decreasing benefits during the public health emergency. SB 21-211 reversed the reduction and restored the funding. The cap was eliminated completely in the FY 2023-24 long bill.
- HB 20-1362 Nursing Facility Reduction: Limited the annual increase for nursing facility rates from 3.0% to 2.0% for FY 2020-21 and FY 2021-22, which reduced appropriations by $7.0 million total funds, including $3.3 million General Fund, in FY 2020-21 and $16.5 million total funds, including $8.3 million General Fund, in FY 2021-22 and ongoing. This reduction was not restored; however, the nursing facility rates increased by 10.0% in FY 2023-24 per HB 23-1228.
- HB 20-1384 Delaying SB 19-195 Wraparound Services: Delayed a program created under SB 19-195 that provides wraparound services for children and youth in or at risk of out-of-home placement. It reduced state expenditures by $1.8 million total funds, including $1.0 million General Fund in FY 2020-21 and $10.8 million total funds, including $5.6 million General Fund, in FY 2021-22 and ongoing. The funding for this program was restored in the FY 2021-22 long bill to allow HCPF to restart the implementation of SB 19-195.
- HB 20-1385 Use of Increased Medicaid Match: Allowed the state to use a temporary increase in federal funds related to Medicaid from the Families First Coronavirus Response Act to reduce General Fund obligations rather than having the benefit accrue to cash funds. It reduced appropriations by $24.7 million General Fund in FY 2019-20 and $26.8 million General Fund in FY 2020-21. The provisions in the bill were extended

past FY 2020-21 through SB 21-213 as the public health emergency and enhanced federal match continued to be extended. HCPF's FY 2024-25 appropriations and FY 2025-26 base budget account for the phase down of the enhanced federal match and corresponding increase in General Fund to make up the difference.

- HB 20-1386 HAS Fee Offset: Authorized the use of hospital fee revenue to offset General Fund expenditures for Colorado's Medicaid program in the amount of $161 million for FY 2020-21 only. This reduction was one-time in nature.

4. **Please provide the most current information possible. For all line items with FTE, please show:**
    a. **the number of allocated FTE each job classification in that line item**
    b. **the number of active FTE for each of those job classifications**
    c. **the number of vacant FTE for each of those job classifications**
    d. **the vacancy rate for each of those job classifications**

    Use the attached Template C to populate these data. Please return the data in editable Excel format.

RESPONSE

See the attached Template C for FY 2024-25 FTE information.

5. **Please provide the same information as Question #4 for FYs 2022-23 and FY 2023-24. Use the attached Template C to populate these data. Please return the data in editable Excel.**

RESPONSE

See the attached Template C for FY 2022-23 and FY 2023-24 FTE information.

6. **For FYs 2022-23 and 2023-24, please provide, in editable Excel format, department-wide spending totals for each of the following object codes, by fund source.**
    a. **Object Code 1130: Statutory Personnel & Payroll System Overtime Wages**
    b. **Object Code 1131: Statutory Personnel & Payroll System Shift Diff. Wages**
    c. **Object Code 1140: Statutory Personnel & Payroll System Annual Leave Payments**
    d. **Object Code 1141: Statutory Personnel & Payroll System Sick Leave Payments**
    e. **Object Code 1340: Employee Cash Incentive Awards**
    f. **Object Code 1350: Employee Non-Cash Incentive Award**
    g. **Object Code 1370: Employee Commission Incentive Pay**
    h. **Object Codes 1510, 1511, 1512: Health, Life, and Dental Insurance**
    i. **Object Code 1524: PERA – AED**

j. Object Code 1525: PERA - SAED

k. Object Code 1531: Higher Education Tuition reimbursement

RESPONSE

FY 2022-23 Expenditures by Object Code

Budget Object Code	Cash Funds	Federal Funds	General Fund	Reappropriated Funds	Total Funds
1130	$0	$2,964	$988	$0	$3,952
1140	$12,789	$116,568	$75,162	$4,092	$208,612
1141	$0	$11,256	$8,054	$0	$19,310
1340	$19,438	$263,848	$210,649	$8,374	$502,309
1510	$22,822	$205,518	$145,288	$5,903	$379,531
1511	$471,578	$4,323,024	$3,065,682	$124,850	$7,985,134
1512	$4,588	$41,367	$29,411	$1,243	$76,609
1524	$165,244	$1,628,056	$1,164,543	$47,813	$3,005,657
1525	$165,083	$1,628,056	$1,164,704	$47,813	$3,005,657
Total Funds	$861,543	$8,220,658	$5,864,481	$240,089	$15,186,770

*There were no expenditures in Budget Object Codes 1131, 1350, 1370, and 1531.

FY 2023-24 Expenditures by Object Code

Budget Object Code	Cash Funds	Federal Funds	General Fund	Reappropriated Funds	Total Funds
1140	$5,804	$116,126	$98,642	$2,966	$223,538
1141	$0	$5,078	$2,808	$0	$7,886
1340	$23,902	$307,674	$259,584	$7,904	$599,064
1510	$23,034	$260,200	$201,417	$5,583	$490,233
1511	$508,860	$5,689,599	$4,427,914	$131,855	$10,758,228
1512	$4,463	$49,604	$37,932	$1,370	$93,368
1524	$157,069	$2,034,860	$1,561,783	$48,763	$3,802,475
1525	$157,069	$2,034,858	$1,561,785	$48,763	$3,802,475
1531	$0	$16,151	$16,151	$0	$32,302
Total Funds	$880,200	$10,514,149	$8,168,017	$247,203	$19,809,569

*There were no expenditures in Budget Object Codes 1130, 1131, 1350, and 1370.

7. **For the latest month for which the data are available, please provide, in editable Excel format, department-wide FY 2024-25 year-to-date spending totals for each of the following object codes, by fund source.**
    a. **Object Code 1130: Statutory Personnel & Payroll System Overtime Wages**
    b. **Object Code 1131: Statutory Personnel & Payroll System Shift Diff. Wages**
    c. **Object Code 1140: Statutory Personnel & Payroll System Annual Leave Payments**
    d. **Object Code 1141: Statutory Personnel & Payroll System Sick Leave Payments**
    e. **Object Code 1340: Employee Cash Incentive Awards**
    f. **Object Code 1350: Employee Non-Cash Incentive Award**
    g. **Object Code 1370: Employee Commission Incentive Pay**
    h. **Object Codes 1510, 1511, 1512: Health, Life, and Dental Insurance**
    i. **Object Code 1524: PERA – AED**
    j. **Object Code 1525: PERA-SAED**
    k. **Object Code 1531: Higher Education Tuition reimbursement**

RESPONSE

The most recent month's expense by object code is not useful data as departments adjust the information through the end of the fiscal year via JVs for revised allocations, POTS adjustments, correcting entries, etc. Therefore, no data will be provided.

8. **For FYs 2022-23 and 2023-24, please provide department-wide spending totals for each of the following object codes, by fund source.**
    a. **Object Code 1100: Total Contract Services (Purchased Personal Services)**
    b. **Object Code 1210: Contractual Employee Regular Part-Time Wages**
    c. **Object Code 1211: Contractual Employee Regular Full-Time Wages**
    d. **Object Code 1131: Statutory Personnel & Payroll System Shift Diff. Wages**
    e. **Object Code 1240: Contractual Employee Annual Leave Payments**
    f. **Object Code 1622: Contractual Employee PERA**
    g. **Object Code 1624: Contractual Employee Pera AED**
    h. **Object Code 1625: Contractual Employee Pera - Supplemental AED**
    i. **Object Code 1910: Personal Services – Temporary**
    j. **Object Code 1920: Personal Services – Professional**
    k. **Object Code 1940: Personal Services – Medical Services**
    l. **Object Code 1950: Personal Services - Other State Departments**
    m. **Object Code 1960: Personal Services – Information Technology**

RESPONSE

FY 2022-23 Expenditures by Object Code

Budget Object Code	Cash Funds	Federal Funds	General Fund	Reappropriated Funds	Total Funds
1210	$0	$1,523,802	$1,231,504	$0	$2,755,306
1622	$0	$2,868	$2,868	$0	$5,736

1624	$0	$1,241	$1,241	$0	$2,482
1625	$0	$1,241	$1,241	$0	$2,482
1910	$12,539	$254,669	$243,130	$0	$510,338
1920	$37,097,037	$116,664,735	$32,068,027	$119,704	$185,949,503
1950	($24,271)	$559,722	$575,233	$16	$1,110,700
1960	$0	$35	$35	$0	$69
Total Funds	$37,085,305	$119,008,314	$34,123,278	$119,720	$190,336,616

*There were no expenditures in Budget Object Codes 1100, 1211, 1131, 1240, and 1940. Budget Object Code 1920 does not include costs for FTE; rather, it includes administrative contracts for HCPF, such as actuarial services, utilization management review, system vendor costs, etc.

FY 2023-24 Expenditures by Object Code

Budget Object Code	Cash Funds	Federal Funds	General Fund	Reappropriated Funds	Total Funds
1210	$0	$1,494,622	$1,232,698	$0	$2,727,320
1622	$0	$9,058	$5,562	$0	$14,620
1624	$0	$3,907	$2,402	$0	$6,309
1625	$0	$3,907	$2,402	$0	$6,309
1910	$86,461	$296,456	$209,994	$0	$592,911
1920	$56,061,505	$170,435,207	$31,489,133	$6,419,506	$264,405,351
1950	$218,058	$1,233,607	$1,013,473	$813	$2,465,951
1960	$0	($35)	($35)	$0	($69)
Total Funds	$56,366,023	$173,476,730	$33,955,629	$6,420,320	$270,218,702

*There were no expenditures in Budget Object Codes 1100, 1211, 1131, 1240, and 1940. Budget Object Code 1920 does not include costs for FTE; rather, it includes administrative contracts for HCPF, such as actuarial services, utilization management review, system vendor costs, etc.

9. **Please provide a table showing both allocated and actual FTE for each Division within the Department from FY 2018-19 through FY 2023-24.**

RESPONSE

All of this information is already included in Schedules 3A and 3B.

10. **Please discuss how the Department would absorb base personal services reductions of the following amounts: 1.0 percent, 3.0 percent, and 5.0 percent. How would those reductions impact the departments operations and core mission?**

RESPONSE

HCPF is willing to provide analysis of information around proposed program cuts and the associated FTE impact of those reductions. Depending on where the reductions to personal services occur, without corresponding reductions in statutory requirements, such reductions would result in longer wait times, reduced abilities, decreased compliance, or a decrease in operational effectiveness. A 1% reduction would mean a reduction of 8.0 FTE, a 3% reduction would mean a reduction of 24.0 FTE, and a 5% reduction would mean a reduction of 40.0 FTE.

Reductions of this magnitude would severely limit HCPF's ability to effectively administer the Medicaid program and implement new initiatives as required by state statute. About 0.5% of HCPF's budget is for FTE costs, which is significantly below other health insurers. A cut to FTE funding would mean HCPF would need to make tough decisions on whether to delay implementation of new programs (for example, continuous coverage for children up to age 3); or scale back current work, such as limiting stakeholder engagement, reducing system testing, restricting oversight and compliance work, etc.

11. Describe steps the Department is taking to reduce operating expenditures for FY 2025-26.

RESPONSE

The Executive Branch's plan for reducing operating expenditures is reflected in the November 1, 2024, budget request.

HCPF administration expenses reflect only 4% of HCPF's overall budget, and staff represent only 0.5% of HCPF's overall budget. Regarding administration expenses, below are some of the ways HCPF is reducing operational expenditures.

- When an employee is separated or retires, HCPF senior executive team members review the position to determine if that position could be eliminated or its work can be performed by an existing position before it is posted.
- HCPF is working to reduce expenditures by up to $200k in reducing desk top telephones as well as web-based phone services for staff who work remote and no longer require these state-funded services.
- Over the last six budget cycles, HCPF has identified an opportunity to enhance several administrative functions by leveraging JBC approval to repurpose funding already appropriated for contractor resources to hire FTE to perform the duties instead. This is done while saving General Fund for HCPF and building in-house expertise and institutional knowledge, thereby accomplishing more of HCPF's, the Governor's, and the General Assembly's goals. Recent examples of the success of previous contractor to FTE conversions include the conversion of provider field representatives in HCPF's FY 2021-22 R-10 budget request; the conversion of Medicaid Management Information System (MMIS) training functions in HCPF's FY 2022-23 R-12 budget request; the conversion of long-term care (LTC) utilization management (UM) functions in HCPF's FY 2022-23 R-12 budget request; and the conversion of payment reform, SUD benefit, and

PEAK Call center staff in HCPF's FY 2024-25 R-13 budget request. If the conversion of county expenditure review, PEAK technical support, and CBMS UAT contractors to HCPF staff is approved in HCPF's FY 2025-26 R-14 budget request, then across all of these conversion requests, HCPF will have reduced contractor costs by $2.2 million General Fund and saved a net total of $439,631 General Funds annually.

- The repurposing of contractor functions to FTE is also critical to improving HCPF agility. Contractors require extensive time to determine and document statements of work (defining needs and requirements), writing requests for proposals, soliciting proposals, evaluating proposals and selecting vendors, writing contracts, and implementing new vendors. Work cannot be started until contracts are executed, delaying work and reducing responsiveness and agility. Comparatively, reallocating contractor funding to FTE – in core competency areas - to address emerging needs is far quicker, effective and more efficient. With FTE, HCPF can meet as a leadership team, consider what to pause and what to reprioritize, then identify the most appropriate talent within the organization to reallocate to address emerging needs, projects and priorities.

- As an example, when COVID hit, HCPF needed to be far more agile in response to challenges which had no playbook. New challenges to tackle during COVID-19, as just a few examples, included: standing up alternative hospital and nursing home care sites in the event of a system breaches, responding to legislative requirements for budget reductions, issuing operational memos to nursing homes to mitigate risk and save lives, getting people vaccinated, making changes in claims systems, passing emergency rules such as telehealth, etc.

As we plan for and eventually implement the policy and fiscal changes coming out of the federal government in the new calendar year and beyond, we will need an extensive level of agility. As we navigate the state's budget challenges, and the policy and fiscal changes coming out of the state legislature, we will need an extensive level of agility. FTE where appropriate – over contractors – can better drive this agility.

12. **For each operating line item, identify the total expenditure at the end of the 3rd quarter for each of the last three fiscal years, as well as the total appropriation for the fiscal year.**

RESPONSE

Table 1 shows HCPF's operating appropriation and expenditure by line item. The appropriation is for the full year, while the expenditure is through quarter 3. It's important to note that operating expenditure does not spend linearly and is typically higher in quarter 4. Final expenditure for each year listed is significantly closer to the appropriation.

Table 1: HCPF Operating History

Line Item	Fiscal Year	Appropriation	Expenditures through Q3
EDO Operating Expense	2022	$2,932,588	$1,376,859
	2023	$3,534,070	$1,598,493
	2024	$3,742,348	$1,866,172
OCL Operating Expense	2022	$281,510	$20,767
	2023	$281,510	$40,685
	2024	$431,510	$69,142

HCPF's operating budget increases incrementally with increases in newly appropriated staff across HCPF, primarily for one-time costs associated with computers/software, telephone, furniture, and office supplies. From FY 2021-22 to FY 2022-23, the increase was also driven by an increase of $467k related to one-time costs for the Office of Administrative Courts and internal staff to address the increase in workload associated with the Public Health Emergency unwind activities, as appropriated in FY 2022-23 S-6, "PHE Funding." The increase from FY 2022-23 to FY 2023-24 was driven by an increase of $137k for travel costs for in-reach counselors funded in FY 2023-24 BA-7, "Community-Based Access to Services."

13. **Please provide an overview of the department's service efforts. In your response, describe the following:**
    a. **Populations served by the Department**
    b. **The target populations of the Department's services**
    c. **Number of people served by the Department**
    d. **Outcomes measured by the Department**
    e. **Present and future strategies for collecting customer experience data**

A POPULATIONS SERVED BY HCPF

Colorado Medicaid and Child Health Plan *Plus* (CHP+) provide health care services coverage to any eligible Coloradan based on income and asset qualifications. Colorado Medicaid covers older adults, people with disabilities, adults and children. Child Health Plan *Plus* (CHP+) covers children and pregnant people with higher incomes than those who qualify for Medicaid coverage. Additional eligibility information is on HCPF's webpage[56].

B THE TARGET POPULATIONS OF HCPF'S SERVICES

[56] hcpf.colorado.gov/keepcocovered

The target population of HCPF's services are any Coloradan who qualifies for Medicaid or Child Health Plan *Plus* coverage. Colorado Medicaid coverage provides physical health benefits, dental benefits, and behavioral health benefits. The program is also expanding to include housing services for certain individuals with health-related social needs (HRSN) through an 1115 waiver. CHP+ covers most of the same services as Colorado Medicaid coverage, but for children and pregnant people with a higher income than those who would qualify for Medicaid. The Medicaid program includes additional services available under its Long-Term Services and Supports programs to assist members with disabilities and older adults with activities of daily living. Some members who are over income for full Medicaid coverage may qualify for family planning services only under Medicaid, and some older adults who are over income are able to access dental services through the Senior Dental Program. In addition, HCPF is implementing Medicaid and CHP+ expansions for children and pregnant adults regardless of immigration status, as authorized under HB 22-1289.

Note that as targeted populations are added to the array of coverages and services HCPF administers, so too will the number of FTEs increase, in accordance with the fiscal notes and additional new work taken on by HCPF at the request of the General Assembly.

C NUMBER OF PEOPLE SERVED BY HCPF

HCPF serves 1,208,231 members under Medicaid and 92,069 under the CHP+ program as of November 2024. As of November 2024, 52,284 members have access to additional waiver services through HCPF's Long-Term Services and Supports and Intellectual and/or Developmental Disabilities Waiver programs. HCPF serves 4,621 individuals through the Senior Dental Program and anticipates expanding to approximately 15,000 individuals through the expansions under HB 22-1289.

D OUTCOMES MEASURED BY HCPF

Outcome measurements are included in all aspects of our agreements to include financial accountability, quality measurement, member satisfaction, and all key performance indicators (KPIs) in our contracts. Examples of this include Healthcare Effectiveness Data and Information Set (HEDIS), Medical Loss Ratio (MLR), Consumer Assessment of Healthcare Providers and Systems (CAHPS), utilization and claims data across all programs, care coordination engagement, credentialing and all aspects of KPIs within the Accountable Care Collaborative (ACC) program. Additionally, HCPF collects or measures utilization, cost trends and community/provider inputs.

HCPF tracks Medicaid expenditure information monthly to measure the most recent 12 months of expenditures by line of business such as inpatient hospital, pharmacy, physician services and other categories. The dashboard also tracks expenditures by population such as low-income adults, foster care children, over 65 and other populations.

E PRESENT AND FUTURE STRATEGIES FOR COLLECTING CUSTOMER EXPERIENCE DATA

PRESENT STRATEGIES FOR COLLECTING CUSTOMER EXPERIENCE DATA

HCPF leverages a multifaceted customer experience strategy that includes collecting data through both direct and indirect channels. Customer experience data is used to measure, monitor and evaluate HCPF's performance on member and provider support touchpoints as well as members' overall experience in accessing Health First Colorado health coverage. Data includes quantitative and qualitative, evaluating service level metrics in addition to attitudinal and experience data. The compilation helps us to understand customer pain points and identify areas for improvement across the member journey.

1. **Contact/Service Centers**. The contact centers provide service through live chat, chatbot and phone and include the Member Contact Center, PEAK Help Desk, CMAP Application Line, Enrollment Broker, the Provider Call Center, 11 large counties and other contracted partners. Many centers conduct random quality assurance reviews and after contact surveys as well as track standard contact center metrics such as total incoming calls, average speed of answer, abandonment rate, average handle times, first call resolution, ticket types/contact reasons and agent staffing. Centers that leverage HCPF's cloud-based technology also have 100% call recording. In addition to collecting data on the members' experience when contacting us, the contact reasons/ticket types help us understand member pain points and identify areas for improvement in the Health First Colorado and CHP+ health coverage.

2. **Websites**. Websites include HealthFirstColorado.com, HCPF.Colorado.gov and CO.gov/PEAK. We collect data and monitor the customer experience through website analytics and surveys. Analytics provide information on webpage traffic, keyword searches and customer behavior patterns to identify areas where customers experience challenges. Surveys are offered to provide the customer an opportunity to share issues with the website, specific website content, or more generally with their Health First Colorado and CHP+ coverage.

3. **Health First Colorado Mobile App**. The Health First Colorado Mobile App provides a quick and easy way for members to manage and use their benefits, offering a digital member card, provider directory, member handbook, basic account management and reminders to keep their information and coverage current. Member experience data is collected when testing updates and changes, in the app store reviews, and proactively requesting feedback in the app. Weekly monitoring includes evaluating metrics such as app store rating, crash rate, application not responding rate, active users, and customer behavior patterns to identify areas where customers experience challenges as well as responding to feedback addressing members' issues and concerns.

4. **Grievances (Complaints).** The grievance process is a well-established mechanism that members can use to file a complaint either directly or with assistance from the ombudsman, their health plan or county (the county grievance process has resources requested in HCPF's FY 2025-26 R-07 request). Complaints can be about anything other than an adverse benefit determination and can include issues with a provider or a service. We monitor the customer experience through formal grievances submitted directly to HCPF as well as through partners such as Regional Accountable Entities (RAEs), Case Management Agencies (CMAs) and counties.

5. **Appeals**. The appeals process is also a well-established mechanism that members can use to disagree with a decision made on a coverage or service request. Members can file an appeal either directly or with assistance from the ombudsman, their health plan or county. Appeals data identifies areas of improvement when applying for and renewing coverage and accessing care through Health First Colorado.

6. **Surveys.** The delivery channel, frequency, purpose, and audience of each survey vary. Surveys are conducted after key interactions to gather immediate feedback to measure performance such as: 90-day reconsiderations, disenrollment experience, online application experience, member onboarding experience and contact center after-contact surveys. Surveys are also conducted to evaluate experiences with health care quality, program operations and policy such as: Consumer Assessment of Healthcare Providers and Systems (CAHPS), County Member Experience, What's Working/Not Working, Transportation, Home and Community-Based Services (HCBS) Coordination, National Core Indicator – Aging and Disabilities, National Core Indicator – Intellectual and Developmental Disabilities, Children's HCBS Survey and website feedback and performance. External, reliable health care survey sources such as the Colorado Health Access Survey (CHAS) issued by the Colorado Health Institute are also utilized to inform and drive policy decisions and program improvements.

7. **Focus Groups, Virtual and In-Person**. We hold a monthly meeting for the Member Experience Advisory Council (MEAC) members, and a monthly meeting for the MEAC Alumni members. Community Based Organizations (CBOs) who applied for and received grant funding also operate meetings to engage and support members in their local communities including those who are non-English speaking and underserved. During these meetings, members share their lived experiences with applying for and renewing coverage, accessing care, and in using our member support services for Health First Colorado. Members also provide input into existing and new communications, processes, programs and policies, and assist in user testing of digital platform changes, all of which help us to learn about member pain points and identify areas for improvement.

8. **Community Ambassador Program.** We partner with 17 Community Based Organizations (CBOs) across the state who applied for and receive grant funding. CBOs host community engagement sessions, education events and collect lived experience and qualitative data on Health First Colorado and CHP+. CBOs also host community

enrollment events where community members can receive assistance with applying for health coverage through PEAK or on paper. Ambassador CBOs offer services and events in a multitude of languages including Spanish, Vietnamese, French, Amharic, Dari, Ethiopian and can offer application assistance in multiple other languages through On-Demand Translation services. CBOs share feedback with HCPF on the current member and applicant experience. The data collected is used to improve the experience and influences changes to Health First Colorado.

9. **Application and Renewal Processing Timelines.** We evaluate customer experience through the statewide monitoring of renewal and application processing timeliness for counties, eligibility sites, case management agencies and the disability determination vendor. Processing times help us understand whether members are receiving coverage access and decisions timely. We use the data to hold sites accountable through internal accountability practices when the information may demonstrate expectations are not being met within any specific site.

10. **Digital Engagement Campaigns.** We collect customer experience data on our digital engagement campaigns to ensure that our communications and messages are effectively reaching the intended audience and that our members have continued engagement. Campaigns and communications examples include monthly member newsletters, information blasts on benefits, renewal reminders, update your contact information, and are delivered in the members' language of preference. We monitor and track email and text campaign metrics such as delivery rates, bounces, opens, click throughs, and unsubscribes.

Future Strategies for Collecting Customer Experience Data

For our future strategies, we are planning to expand and enhance our data collection with the following initiatives:

1. **Contact/Service Centers**. We plan to continue work with county (depending on County Incentives Program appropriations) and partner contact centers to expand the collection of customer experience data and standardize the service level expectations across the state.

2. **Leveraging Appeals Data to Improve Correspondence.** After the updating of eligibility correspondence in the summer of 2024, we plan to complement the eligibility correspondence monitoring dashboard and the live correspondence review with the evaluation of appeals data to identify areas where language continues to be unclear and initiate additional improvements accordingly.

3. **Improvements to the Health Needs Survey.** Over the coming months, we plan to improve customer experience data collection through the health needs survey. Based on feedback from MEAC, the survey has been updated to include more clear and relevant questions. We will be expanding access to the survey to more channels, resulting in increased participation during member onboarding. Finally, we are

instituting a more effective response and follow up process enabling the RAEs to connect with members who ask for assistance through the health needs survey.

4. **Provider Directory Feedback Loop.** Contingent upon funding, we plan to initiate a feedback loop allowing members to report discrepancies in the online provider directory data. The discrepancy reports will be sent to the Regional Accountable Entities (RAEs) who will follow up with the provider and obtain updated directory information.

5. **Focus Groups Expansion.** Contingent upon funding, we will expand the MEAC and MEAC Alumni roles to comply with the new federal regulations (42 CFR 431.12). The result of this expansion will be a blended council including health care providers, stakeholders, and Health First Colorado members or family members willing to share their lived experiences. The Council will produce an annual report of recommendations to HCPF, who will be accountable for the review and response to the recommended actions. Additionally, the new Accountable Care Collaborative (ACC) reprocurement supports the regional expansion of member advisory councils. This expansion will provide additional opportunities for members to provide feedback on their lived experiences in accessing care through Health First Colorado coverage.

6. **Robust and Real-Time Feedback System.** We plan to implement a robust and real-time survey and website analytics tool, Qualtrics, for the CO.gov/PEAK website. This will allow applicants and members to provide input instantly during their application or renewal experience, as well as more comprehensive tracking of customer behavior patterns to identify where customers are struggling with the website.

7. **Analysis of Root Causes of Member Complaints and Escalations to Drive Improvements**. We plan to analyze financial eligibility complaints and escalations from members, providers and advocates to understand the root causes of those escalations to drive best practices across counties, Medical Assistance sites and systems to improve the member experience.

By maintaining and adding new strategies, we aim to continuously enhance our understanding of the Health First Colorado and CHP+ member experience and deliver efficient, effective and customer-centric services.

14. For each TABOR non-exempt cash fund, provide the following information:
   - **a. The amount in the cash fund**
   - **b. Total amount of revenue in the fund that would not be transferred**
   - **c. Detailed explanation of why the fund should not be sunset**
   - **d. Statutory reference of the fund creation, specific uses, and legislative history of changes to the fund**
   - **e. Every program funded by the fund**
   - **f. Explanation of how fees to the fund are set and a history of fee changes**

g. The number of people provided service by the programs funded through the cash fund
h. Any additional information necessary to ensure the Joint Budget Committee can make an informed decision.

RESPONSE

Much of this information is in the Schedule 9 HCPF submitted on November 1, 2024. Below is additional information on each cash fund.

Service Fee Fund (16Y0)

a. Cash fund balance of $52,737 as of July 1, 2024.
b. Health Care Provider Fee revenue is TABOR non-exempt. All revenue is anticipated to be expended.
c. This fund should not be sunset as it provides additional reimbursements to intermediate care facilities. Sunsetting the fund would essentially be a rate cut to that provider group.
d. 25.5-6-204 (1)(C)(II), C.R.S. (2024). The fund is primarily used to provide reimbursements to intermediate care facilities for services rendered for individuals with intellectual disabilities.
e. Medicaid program and intermediate care facilities for individuals with IDD.
f. Service fees are collected from private and public intermediate care facilities who provide care for individuals with intellectual disabilities. Fee level is set by the Medical Services Board, not to exceed five percent of the total costs incurred by all intermediate care facilities.
g. In FY 2023-24, 121 unique members utilized services in intermediate care facilities.

Medicaid Nursing Facility Cash Fund (22X0)

a. Cash fund balance of $1,024,313 as of July 1, 2024.
b. Health Care Provider Fee revenue and interest income is TABOR non-exempt. All revenue aside from interest is anticipated to be expended.
c. This fund should not be sunset as it primarily provides additional reimbursements to nursing facilities. Sunsetting the fund would essentially be a rate cut to that provider group.
d. 25.5-6-203 (2)(a), C.R.S. (2024). The purpose of this fund is to deposit nursing facility provider fees, pay for the administrative costs of implementing new reimbursement rates, pay a portion of the new per diem rates established under 25.5-6-202, C.R.S, and satisfy settlements or judgments from nursing facility provider reimbursement appeals.
e. Medicaid program.

f. HCPF is required to collect a Quality Assurance Fee from nursing facilities, including facilities that do not serve Medicaid members. Each year the fee is increased by inflation based on the national skilled nursing facility market basket index determined by the Secretary of Health and Human Services for future years.
g. In FY 2023-24, 12,867 unique members utilized services in nursing facilities.

Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D0)

a. Cash fund balance of $3,797,465 as of July 1, 2024.
b. Motor Vehicle Registration revenue and interest income is TABOR non-exempt. All revenue is anticipated to be expended.
c. This fund should not be sunset as it provides the state share for members enrolled in Medicaid with breast and cervical cancer who would otherwise be ineligible. Sunsetting the fund would mean either backfilling the state share with General Fund or eliminating the eligibility group.
d. 25.5-5-308 (8)(a), C.R.S. (2024). The purpose of the fund is to provide for the prevention and treatment of breast and cervical cancer for women for whom it is not otherwise available for reasons of cost.
e. Medicaid program and behavioral health program.
f. Per 42-3-217.5 (3)(c), C.R.S., a $25 surcharge is on breast cancer awareness special license plates are to be deposited in the Eligibility Expansion Account within the Fund. Because the eligibility expansion has been authorized, ongoing revenue collections are deposited in the main fund. The license plate surcharge does not qualify as a "fee" pursuant to section 24-75-402(2)(e)(V), C.R.S.
g. There was an average of 119 members enrolled in Medicaid through the breast and cervical cancer program in FY 2023-24.

Adult Dental Fund (Fund 28C0)

a. Cash fund balance of $796,479 as of July 1, 2024.
b. Interest income is TABOR non-exempt. All revenue is anticipated to be expended.
c. This fund should not be sunset as it provides the state share for dental services utilized by adults enrolled in Medicaid that would otherwise have to be paid with General Fund. Sunsetting the fund would mean either backfilling the state share with General Fund or eliminating the dental benefit for adults.
d. 25.5-5-207 (4), C.R.S. (2024). The purpose of the fund is to provide for the direct and indirect costs associated with the implementation of a limited oral health benefit for adults in the Medicaid program.
e. Medicaid program.

f. There are no fees for this fund.
g. In FY 2023-24, 224,393 unique adult members utilized dental services.

Department of Health Care Policy & Financing Cash Fund (Fund 23G0)

a. Cash fund balance of $195,176 as of July 1, 2024.
b. Medicaid Provider Enrollment Fees are TABOR non-exempt revenue. All revenue is anticipated to be expended.
c. Provider enrollment fees are federally required. There must be a mechanism to collect the fees and deposit them in a cash fund.
d. 25.5-1-109, 25.5-5-304(3)(C)(II) C.R.S. (2024). The purpose of the fund is to collect fees or otherwise by HCPF. Moneys from the fund shall be appropriated by the General Assembly for the direct and indirect costs of HCPF's duties as provided by law.
e. Senior Dental Program and MMIS maintenance and projects.
f. Fee revenue currently consists of provider screening fee revenue which, pursuant to federal regulations under 42 CFR § 455.460, must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government.
g. This cash fund is administrative only and does not support a specific program.

Medicaid Buy In Cash Fund (Fund 15B0)

a. Cash fund balance of $108,845 as of July 1, 2024.
b. Medicaid premiums are TABOR non-exempt revenue. All revenue is anticipated to be expended.
c. Members enrolled in the Medicaid Buy-In Programs for People with Disabilities are required to pay a fee to be enrolled into Medicaid, which are deposited into this cash fund. The fund can be sunset only if the fees are set to $0. HCPF requested for the revenue to be deposited into the Healthcare Affordability and Sustainability Fee cash fund, which is TABOR exempt, in the FY 2025-26 R-16, “Medicaid Financing Reductions.”
d. 25.5-6-1404 (3) (b), C.R.S. (2024). The purpose of the fund is to pay for implementation and administration of the Medicaid Buy-In Programs for People with Disabilities.
e. Medicaid program.
f. Medicaid premiums will be paid by members eligible for and participating in the program based on a sliding-fee scale.
g. There was an average of 20,312 members enrolled in Medicaid through the buy-in programs in FY 2023-24.

Colorado Family Support Loan Fund (Fund 2675)

a. Cash fund balance of $89,457 as of July 1, 2024.
b. Interest income is TABOR non-exempt revenue. There are no expenditures that post against this cash fund.Mic
c. This fund could be sunset once the fund balance is utilized.
d. 25.5-10-305.5, C.R.S. (2024). The Family Support Services Fund consists of prior transferred funds and any new revenue resulting from repayments of outstanding loans issued through the Family Support Loan Program.
e. There are no fees for this fund.
f. Family support services program.
g. While there was an average of 4,837 individuals that received services from the family support services program, there is no direct appropriation from the Colorado Family Support Loan Fund.