Joint Budget Committee Hearing
Health Care Policy & Financing

January 6, 2025

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Ralph Choate, Medicaid Operations Office Director
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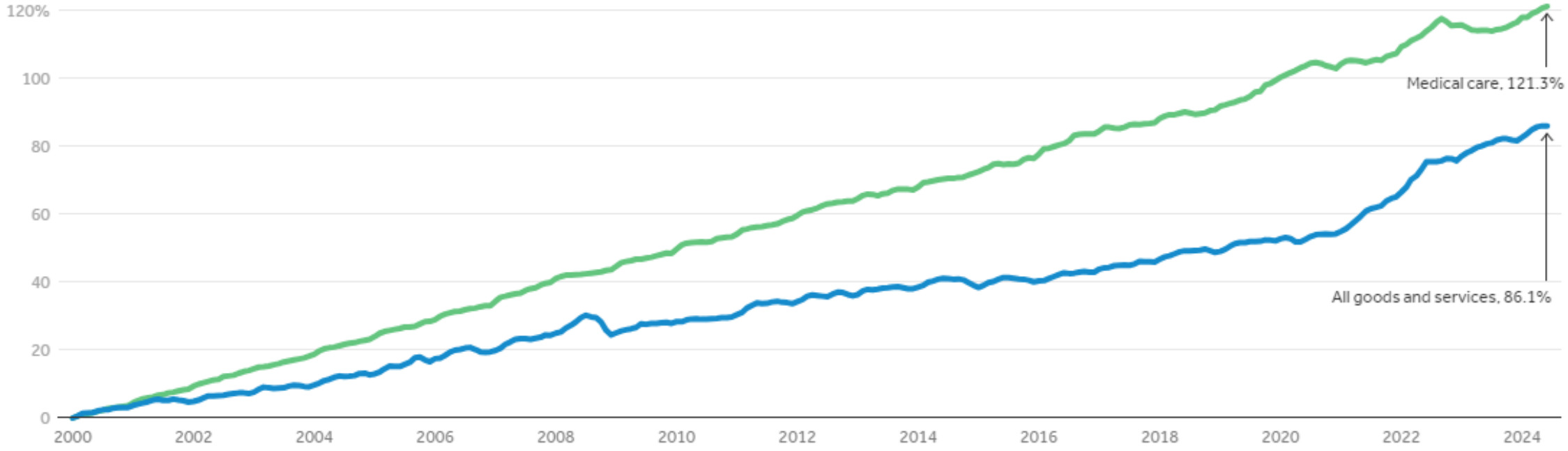
Medicaid's Continual Pressure on CO Budget
Medical Trend vs TABOR Revenue Trends

- Since 2000: medical inflation increased by 121.3%, prices for all goods and services increased by 86.1%
- U.S. medical care services CPI rose 2.0% in 2019, 5.1% in 2020, 0.4% in 2021, 4.5% in 2022 and 0.1% in 2023.
- June 2024: medical care increased by 3.3%, overall annual inflation increased by 3%

Cumulative percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care and for all goods and services, January 2000 - June 2024



Note: Data are not seasonally adjusted. Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data • Get the data • PNG

Peterson-KFF Health System Tracker

Trend Drivers: Provider Reimbursements

- HCPF is 31% of state's General Fund. 96% goes to providers
- FY 2021-22 – FY 2024-25 = 9.5%, compound to 10%. FY 2010-11 - FY 2019-20 = 6.3% compounded, average annual increase of 0.62%
- Targeted Rate Increases: FY 2021-22 – FY 2024-25: $434.5M total funds and $149.3M General Fund, average of $108.6M TF, $37.32M GF each year. Pre-pandemic average of $20M TF, $9.4M GF

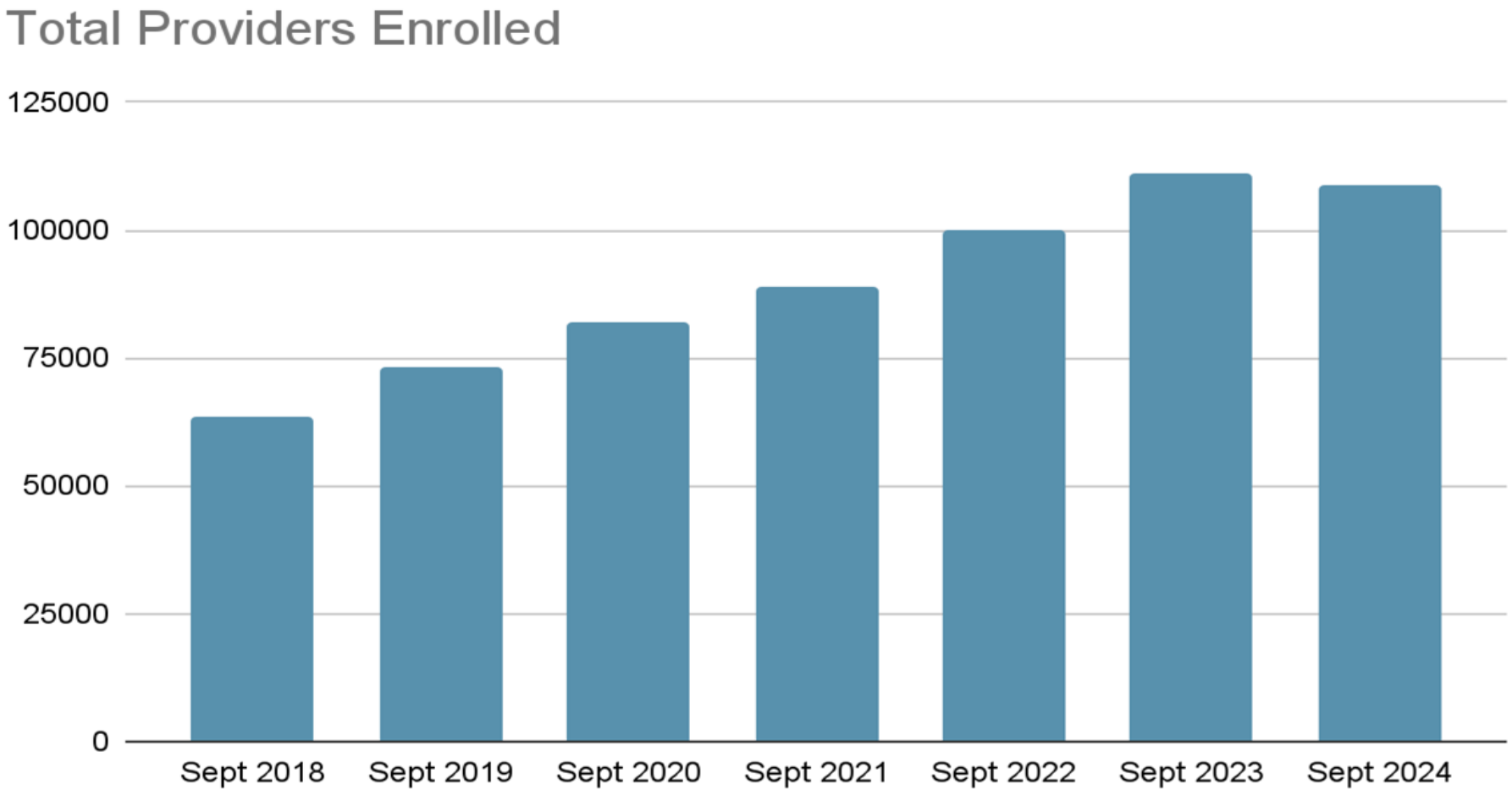
Fiscal Year	Total Funds	General Fund
FY 2018-19	$24,591,832	$11,565,718
FY 2019-20	$15,457,091	$7,237,879
FY 2020-21	$1,905,204	$1,389,576
FY 2021-22	($4,204,227)	$2,662,375
FY 2022-23	$111,743,414	$42,740,454
FY 2023-24	$128,810,841	$42,357,335
FY 2024-25	$198,146,802	$61,534,447

Includes rate increases from the rate review process, HCBS base wage increases, and other targeted rate adjustments

Rate Change	Across-the-board
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%

Medicaid's Improved Network Access to Care

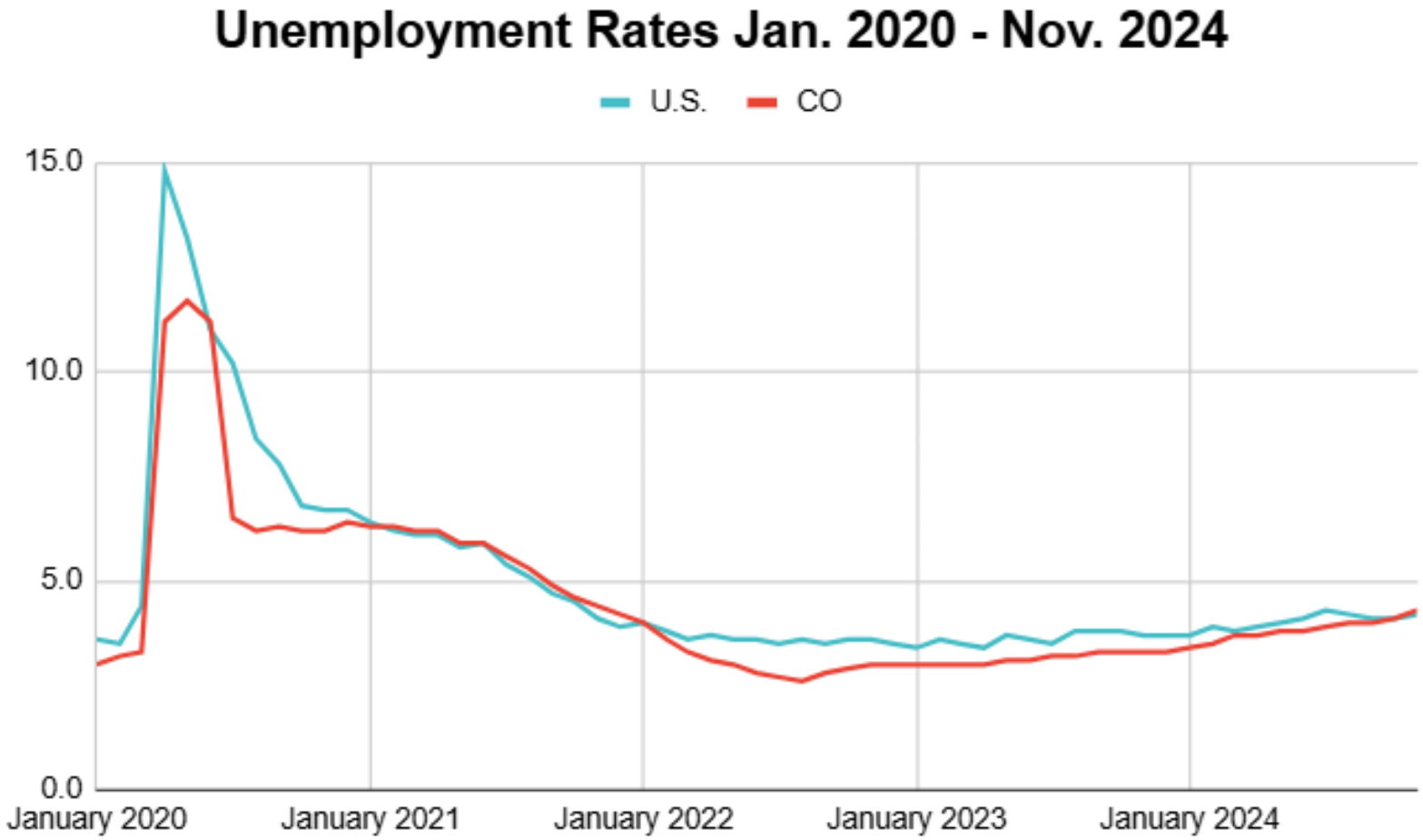
- Hard work to provide greater Medicaid member care access to close disparities and improve health
- 2018-2024: We grew Medicaid network by 70+%
- Now, greater network access to a smaller population, post PHE Unwind



Medicaid/CHP+ Enrollment	1,376,366	1,297,572	1,411,977	1,579,221	1,729,242	1,625,529	1,282,887

The slight decrease from 2023-2024 is due to providers that did not complete the federally required revalidation process.

Economic conditions impact Medicaid and CHP+ enrollment, member acuity and utilization



Bureau of Labor Statistics, Unemployment rate

- Economic swings impact Medicaid enrollment and membership acuity
- Investments that make the state attractive to employers is also critical to keeping unemployment low.
- CO's unemployment rate recovered 6 mos. faster than nat'l avg., but Nov. surpassed nat'l avg. (CO 4.3%, US 4.2%)
- LTSS not as impacted by economy

Questions 1-3: Medicaid Trend Drivers and Sustainability

FY 2023-24	Medicaid Non-LTSS	CHP+	Total Medicaid	Medicaid LTSS
Enrollment Avg	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

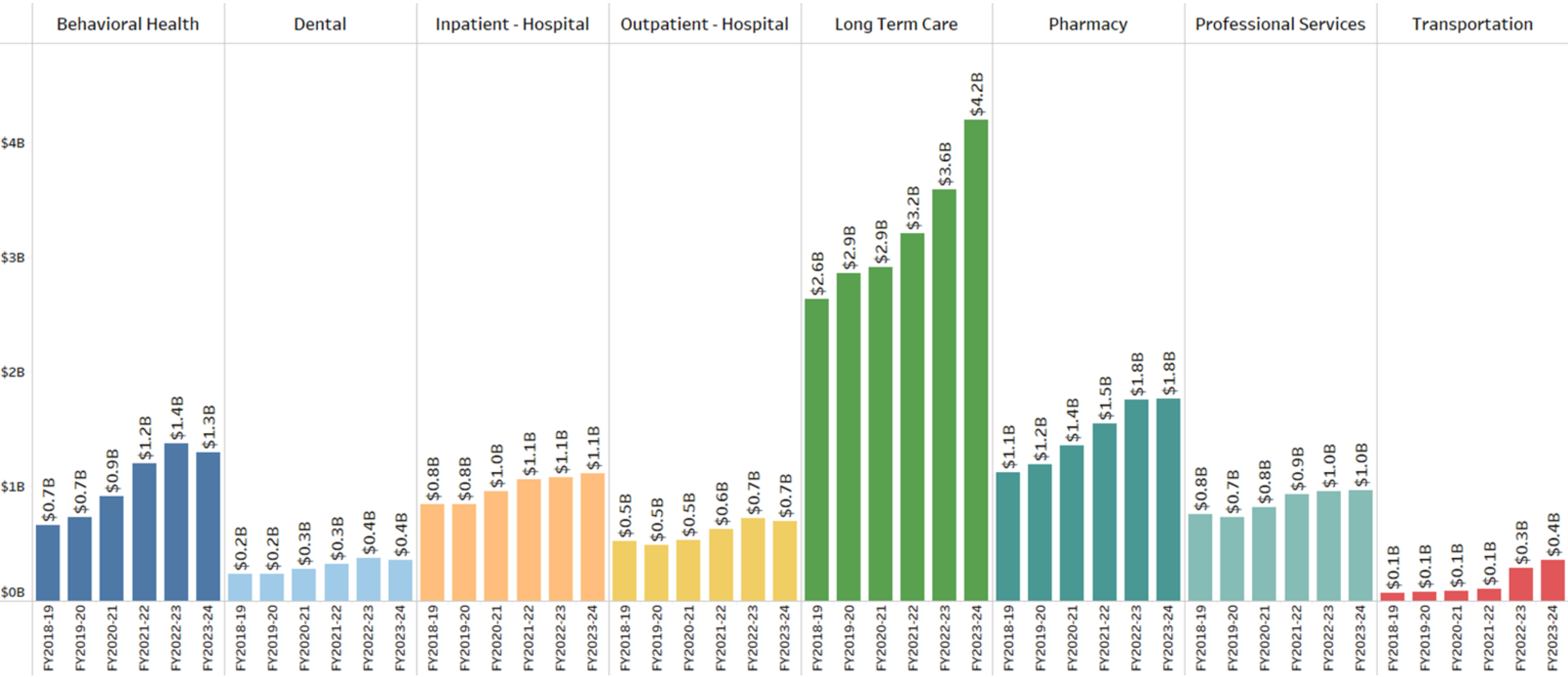
This includes all claim and capitation payments. This does not include payments made outside of claims and capitations, including (but not limited to): supplemental payments to hospitals, nursing facilities, schools, and other providers; Medicare premiums paid on behalf of dually eligible members; drug rebates; and HCPF's administrative costs.

Where are we now against forecast? Using 5 months of data: July - Nov. 2024

- With the exception of behavioral health, expenditures for Medicaid and CHP+ services through November is tracking within 0.15% of the forecast as submitted on November 1, 2024
- Medicaid caseload is tracking within 0.4% of the forecasted enrollment
- Will do deep dive into all service trends in January using data through December and adjust trends accordingly
- This will also include an updated analysis on behavioral health rate trends using more current data

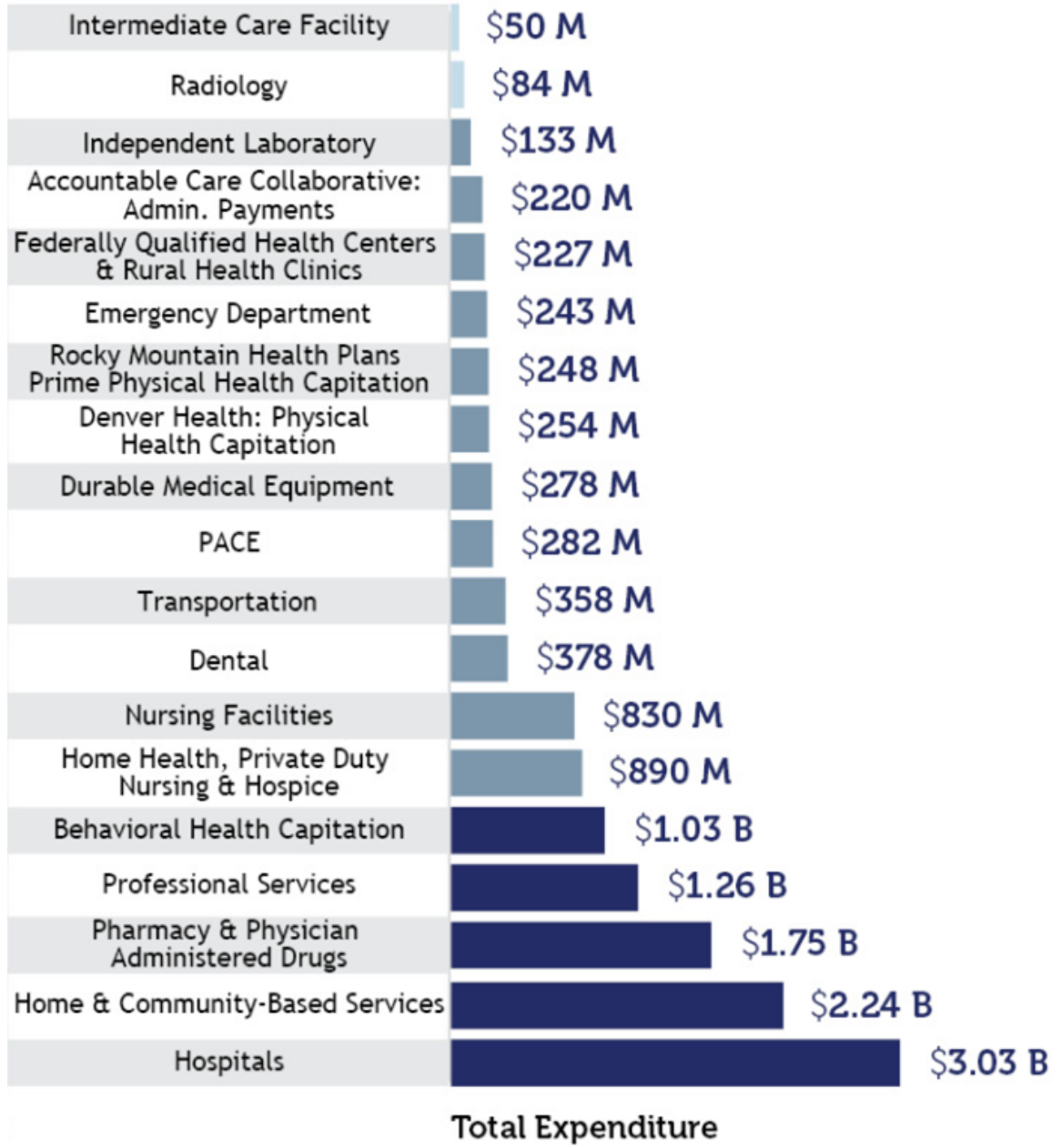
Source: FY 2023-24 (7/1/2023-6/30/2024 with payment run out until 9/30/2024)
Medicaid includes claims and capitation payments only

FY18-19 to FY23-24 Medicaid Benefits Trend



Source note: Includes claims and capitation payments only

FY 2023-24 Medicaid Payments by Provider Type



Source: FY 2023-24 (7/1/2023-6/30/2024 with payment run out until 9/30/2024) from 2023-2024 HCPF Annual Report at CO.gov/HCPF/publications

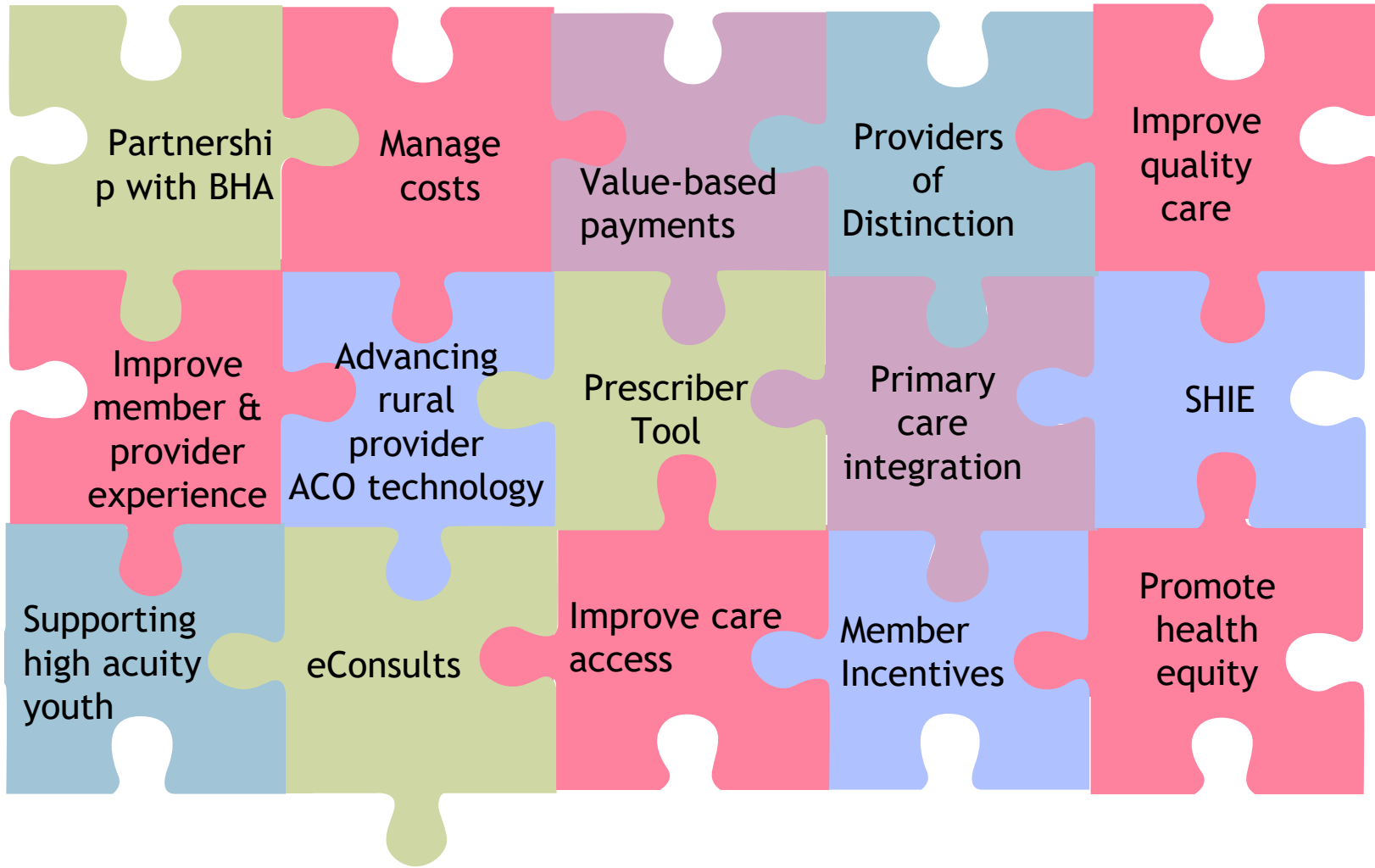
Non-LTSS ~95% of members: 56% of spend

LTSS ~4.7% of members: 42% of spend at higher trend

Since FY 2018-19, LTSS kids under age 18 enrollment is up 50%, while ages 18-64 grew 8% and 65+ grew 5%

Battle Medicaid Trends With ACC Phase III

- Medicaid delivery system, ACC, includes programs to control cost trends and improve member care access, quality outcomes and equity.
- FY 2025-26 R-6 requests funding for ACC Phase III.
- HCPF's expenses at 4% reflect an admin allocation **far** below commercial carriers which better finances operations and trend control.
- **Investing in ACC Phase III is critical to controlling Medicaid trend.**



Medicaid Trend Control through Utilization Management (UM)

Utilization Management (UM) is an important tool to ensure **the right care, in the right setting/place, at the right time, for the right price**. When UM is eliminated or curbed, utilization and claim cost trends rise.

- HCPF is not driving for profits like Commercial carriers do. Proper Medicaid UM techniques better control trend, mitigating benefit cuts or program access cuts.
- When the Behavioral Health utilization review on outpatient services was prohibited (SB22-156), the utilization rate for impacted services increased by 17%.
- HCPF is in the process of re-activating Long Term Home Health Prior Authorizations and Nurse Assessor UM.
- RAC retrospective controls are also important.

Let's improve UM programs together to achieve shared goals, not eliminate them.

Partnering with you to address challenging budget

Examples of opportunities to further evaluate and discuss:

- Adjustments to ATB or specific providers, recognizing that ATB and targeted rate increases have been multiples higher than historic
- Review of specific rate opportunities
- Pursue utilization management opps, while ensuring future alignment
- Increase federal match and drawdown (HRSN, CFC, CHASE, etc.)
- Use increased CHASE dollars as GF offset in HCPF Medical Services Premiums
- Pausing coverage expansions and new initiatives not yet effective (ie: Ages 0-3, Corrections, community workers)
- Adjustments to Cover All Coloradans (ie: removing LTSS waiver coverage or other benefits and/or creating enrollment caps)
- Based on JBC feedback, HCPF can work with you to provide additional info and options to address trend drivers and budget reduction needs

Eligibility performance metrics as of Oct. 2024

	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 at household level)	N/A	33% - All	59% - All **67% - MAGI 41% - Non-MAGI	56% - All **66% - MAGI 33% - Non-MAGI	62% -All **72% - MAGI 36% - Non-MAGI	58% -All **68% - MAGI 33% - Non-MAGI	63% - All **71% - MAG 43% - Non-MAGII	64% - All **70% - MAGI 48% - Non-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%
Disenroll: Procedural	12%	25% (after 90 days)	9% (after 90 days)	8% (after 90 days)	7% (after 90 days)	8% (after 60 days)	11%	10%

*July 2024 marked the implementation of additional automation for renewing members with incomes at and below the federal poverty level. This additional automation is due to a temporary flexibility (known as an e14 waiver) allowed by the federal government through June 2025. HCPF has urged the federal government to make this waiver permanent as it improves the member experience by reducing paperwork needed for renewals and associated county workloads.
**MAGI is Modified Adjusted Gross Income or income based populations. In October 2024, MAGI accounted for 76% of total enrollment.
***Given the renewal volume, the processing backlogs that evolved through the PHE Unwind, our state supervised-county administered structure, and the investments needed in our eligibility systems and staffing to improve capacity and processing time, this 90-day reconsideration period is an important metric for Colorado.

Modern CBMS Ecosystem and Current Add'l Opportunities

- CBMS screens/interface are built on Salesforce. Sept 2024 migration to Hyperforce.
- CBMS eligibility determination uses Corticon rules engine, updated 2023. 2025 upgrade to Micro Services.
- Amazon Web Services (AWS) cloud data storage in the cloud. Regular upgrades.
- Member facing online application and benefits portals: PEAK uses Lightning, which is Salesforce's latest framework. 2023 update. MyCO/MyCOBenefits app to manage food and cash assistance benefits via mobile devices is built on React. Yearly updates.
- PEAKPro simplified eligibility functions. Enhancements in three phases 2023-2024.
- **Current Opportunities/Focus:**
  - Addressing system downtime, in partnership with OIT, HCPF, CDHS, counties.
  - Don't have enough funding for CBMS pool hours or staff to keep pace with state work (ie: bills, county requests) or current and future federal requirements (175-250k pool hour funding shortfall).

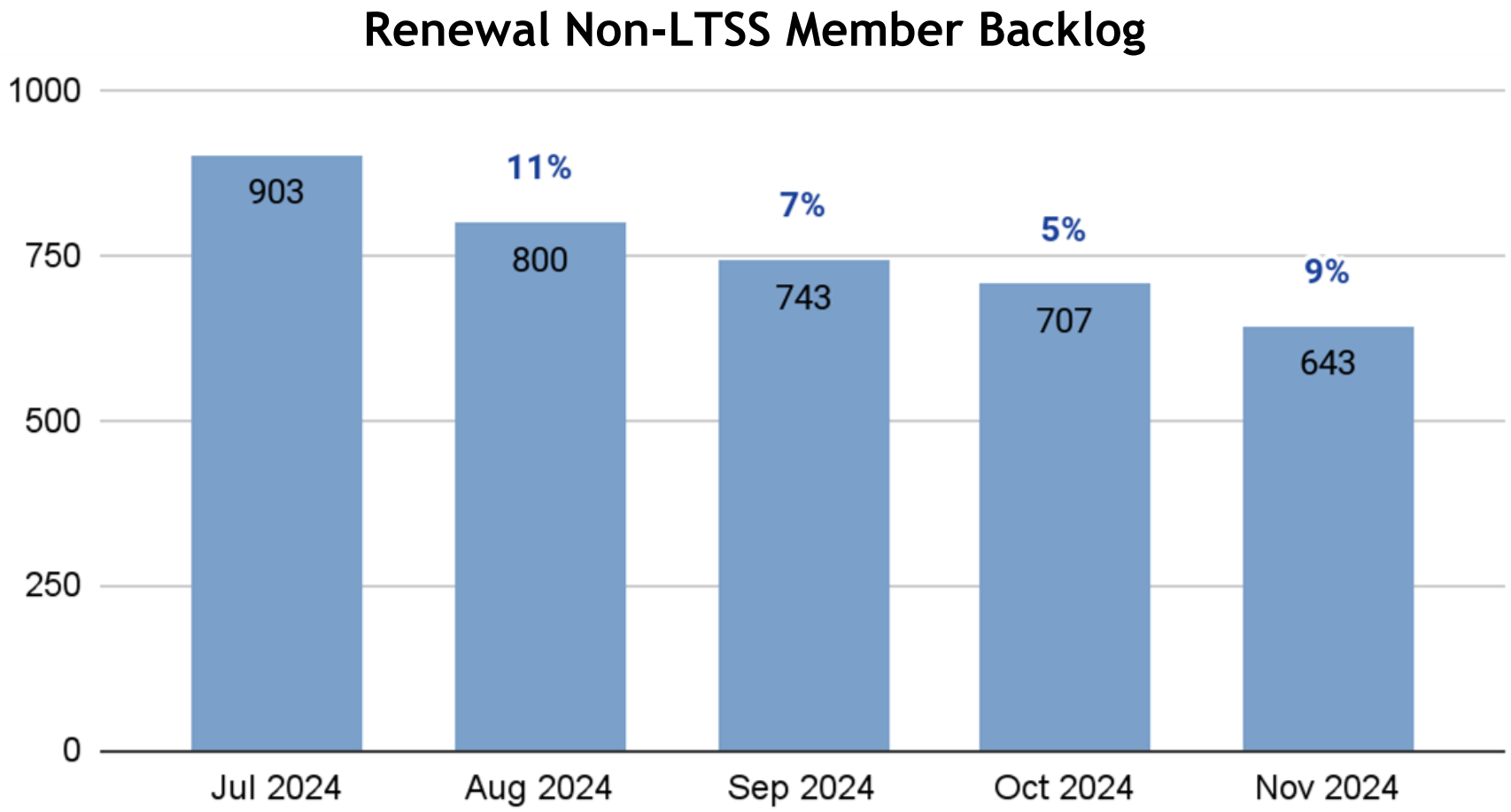
County New Application and Renewals: Caught up the backlog

Application Timeliness

- **Non-LTSS** (goal to process in 45 days): Sept 96%, Oct 96%, Nov 97%
- **LTSS:** (goal to process in 90 days): Sept 96%, Oct 97%, Nov 97%
- Nearly 75% of new applications approved in 10 days or less

Renewal Timeliness

- **Non-LTSS:** (goal to process in 45 days) Sept 92%, Oct 92%, Nov 92%



Backlog is defined as “Exceeding Processing Guidelines”

Prioritizing County Infrastructure - People and Systems

SB 22-235 report to JBC Nov. '24

- New funding model, county workforce to match need and higher salaries to improve county ability to hire/retain
- Intelligent Character Recognition and Interactive Voice Response technology
- Policy guidance improvements
- Service delivery standards and aligning administrative requirements
- Pool hours and supports for training and complex cases

FY 2025-26 R-7 Budget Request

- $38.2M to address above plus CBMS and escalations support

Joint Agency Interoperability Co-Created with Counties

- Unified work management system across counties
- Unified document retention system across counties
- ITN active thru mid Oct. (implementation begins 26/27)

Reducing county workload and improving accuracy

- Improving renewal ex parte automation, PEAK member digital tool capabilities and utilization, and PEAKPro provider/community partner elig. tool

CBMS Strategy and Vision Co-Created with Counties

- Improves CBMS support system for workers and members (target completion: June 2025)

Improve member correspondence accuracy, readability

- Addressed audit findings by revising CBMS letters
- Improvements continue

Critical Priority: Addressing/Mitigating System Downtime!

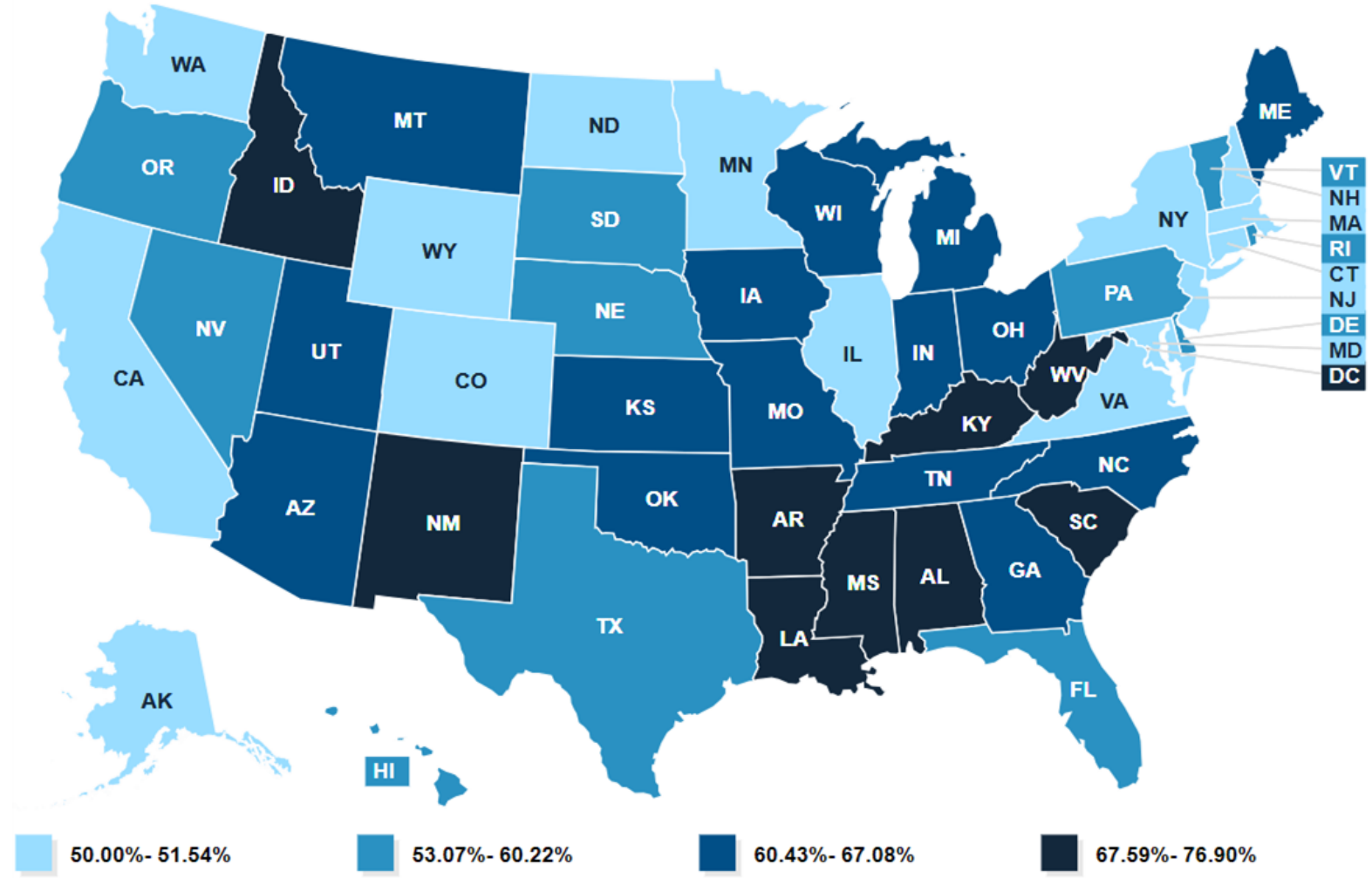
HCPF Admin and FTE Insights

- Health First Colorado (Colorado's Medicaid program)
- Child Health Plan *Plus*
- Buy-In Programs
- The Colorado Indigent Care Program
- Long Term Services and Supports
- Dental Program
- Family Planning
- Cover All Coloradans
- Senior Dental Program
- Health Related Social Needs
- School Health Services

- HCPF's current Admin is **4%**. Commercial carriers ~13%
- An Admin expense 1/3 of Commercial carriers = Efficient
- HCPF covers **1.3M** members; carriers cover 20x to 40x more
- **40%+** of Colorado's children, **40%+** of births, **4.7%** LTSS
- LTSS complexities require more Admin support; **40%+** of spend
- HCPF is administering more programs, as directed (left)
- FTE are less costly and more efficient that contractors; we should leverage that efficiency, converting contractors to FTE
- If FTE help us pull down more federal funds or avoid audit findings and clawbacks, please leverage that
- If FTE enable us to be more nimble - which they did thru COVID - and which we will need going forward, leverage that
- We will do our part, but **FTE are only 0.5% of our budget.**

Source: FY 2023-24 data via HCPF Annual Report at CO.gov/HCPF/publications

Need for HCPF Agility: Emerging Federal Environment Will Impact State Policy and Budgets



- FMAP match or block grants
- Medicaid Expansion 400k @ 90/10 (47k add'l = buy-in, parent caretakers, kids continuous coverage)
- C4H Subsidies (77% or 230k+)
- Provider/CHASE Fees
- Medicaid match: Housing, Food
- FQHC Safety Net Funding
- Undocumented Coloradans
  - Cover All Coloradans
  - Public Charge
- Work Requirements

Source: kff.org/medicaid/issue-brief/medicaid-financing-the-basics

HCPF FY 2025-26 Budget

$17.4B TF, $5.4B GF

- **31%** of state's GF operating budget
- **96%** continues to go to providers, about **4%** admin and **0.5% HCPF staff**

Increase of $1.4B TF, $438M GF, most from: $458M GF — year-over-year growth in Medicaid

Discretionary budget requests ($37.4M TF and $2.3M GF):

- R6 | Accountable Care Collaborative: Phase III
- R7 | County Administration and CBMS Enhancements
- R8 | Colorado Medicaid Enterprise System Administration
- R9 | Provider Rate Adjustments
- R10 | Administrative Alignment
- R11 | Office of Community Living Benefits
- R12 | Integrated Care Benefit
- R13 | Contract True Up
- R14 | Convert Contractor to FTE
- R15 | Pharmacy MAC
- R16 | Medicaid Financing Reduction

Office of Community Living

Bonnie Silva, Director of the Office of Community Living

Long-Term Services and Supports (LTSS) and Home and Community-Based Services (HCBS) Overview, Questions 4-8

Long-Term Services & Supports

Community-Based Care

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

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

Institutional Settings

Nursing Facilities, Intermediate Care Facilities, or Hospital Back-Up Program

Who Receives Long-Term Services & Supports?

15%

Children & Adolescents

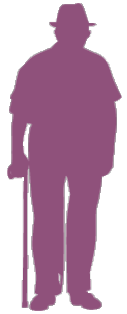
ages 20 & younger & qualifying former foster care youth

45%

Adults

ages 21-64

40%



Older Adults

ages 65 or older

Cross Disability

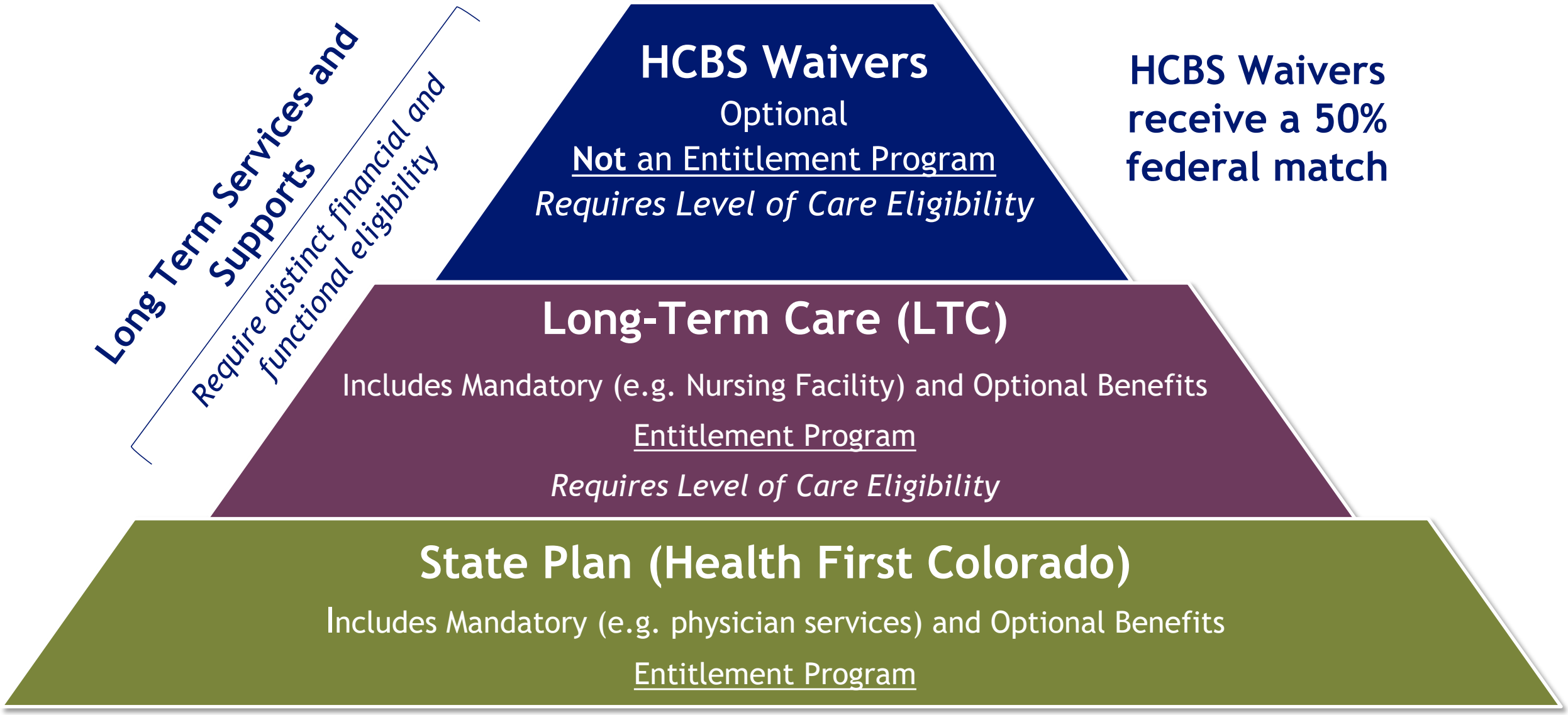
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

86% have a **chronic condition** (compared to 28% of all Medicaid members)

37% have 5 or more chronic conditions

FY 2023-24; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Questions 4-6, Medicaid Benefits Pyramid



HCBS Waivers receive a 50% federal match

Long-Term Services & Supports Programs

Home & Community Based Services (HCBS) Waivers	50,034
State-Funded Only Programs	7,526
Facility-Based Programs	12,628
Program for All-Inclusive Care for the Elderly	5,590
Long-Term Home Health & Private Duty Nursing	5,045

Total Served in LTSS

80,823

SOURCE: FY 2023-24; based on claims in MMIS.

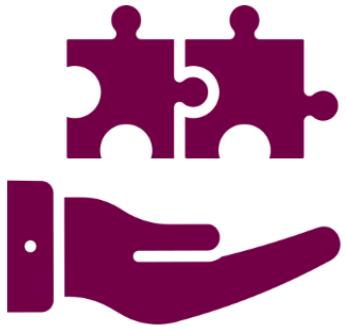
Questions 7-8, HCBS Waivers in Colorado

Adult Waivers	Enrollment
Brain Injury (BI)	684
Community Mental Health Supports (CMHS)	3,637
Complementary & Integrative Health (CIH)	286
Developmental Disabilities (DD)	7,951
Elderly, Blind & Disabled (EBD)	27,404
Supported Living Services (SLS)	4,572

Children's Waivers	Enrollment
Children's Extensive Support (CES)	2,842
Children's Home & Community - Based Services (CHCBS)	2,265
Children with Life Limiting Illness (CLLI)	127
Children's Habilitation Residential Program (CHRP)	266

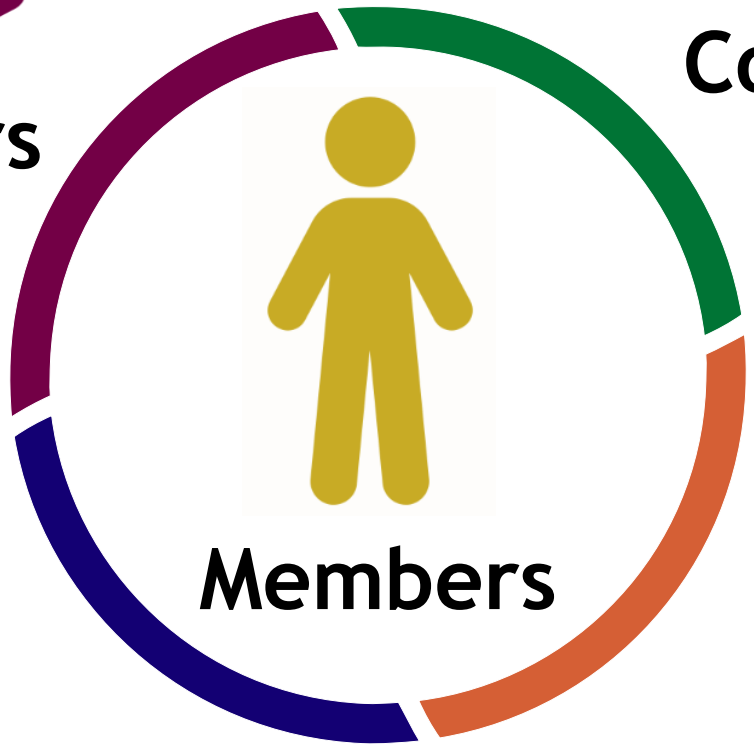
Total Members Served on Waivers: 50,034

Who is Involved in LTSS?



Providers

Counties and Eligibility Sites



Members

Case Managers

Advocacy

Converging Issues Impacting LTSS

PHE Unwind | **County Eligibility Sites** | **Case Management Agencies** | **IT System Issues**

Key Strategies for LTSS Stabilization

Protecting Coverage for LTSS Members

- 12-Month extension on level of care
- Paused terminations & prevented terminations
- Introduced new technology and processes for backlog of disability determinations
- Outreached procedurally terminated members
- Implemented escalation process
- Launched website for consistent communication

Paying Providers Timely to Protect Access to Services

- Provided Provisional Provider Payments
- Implemented a Prior Authorization Request (PAR) and Benefit Plan Extensions
- Filled in eligibility gaps for members to cover services provided

Reducing Case Management Agencies (CMAs) and County Backlog

- Counties:
  - Backlog reduction plans for the five largest counties
  - County performance monitoring
- CMAs:
  - Robust training for new staff
  - Backlog reduction plans
  - Regulatory & policy flexibilities
  - Decrease administrative burden & change for Case managers

Identifying and Resolving Known IT Issues

- 52 items to stabilize system from phase 1; 7 remaining
- Public-facing project plan of additional prioritized items thru 6/2025; Majority will reduce admin burden to CMAs
- Created CMA Super User group; 1:1 weekly support for CMAs
- Changed vendors

Continued Stakeholder Engagement

Vision for LTSS in Colorado

Expanding community based care

Strong Case Management System

Case management has the tools and training to serve all populations

Streamlined Eligibility Process

Ease access to services by simplifying the eligibility processes

Implement Community First Choice

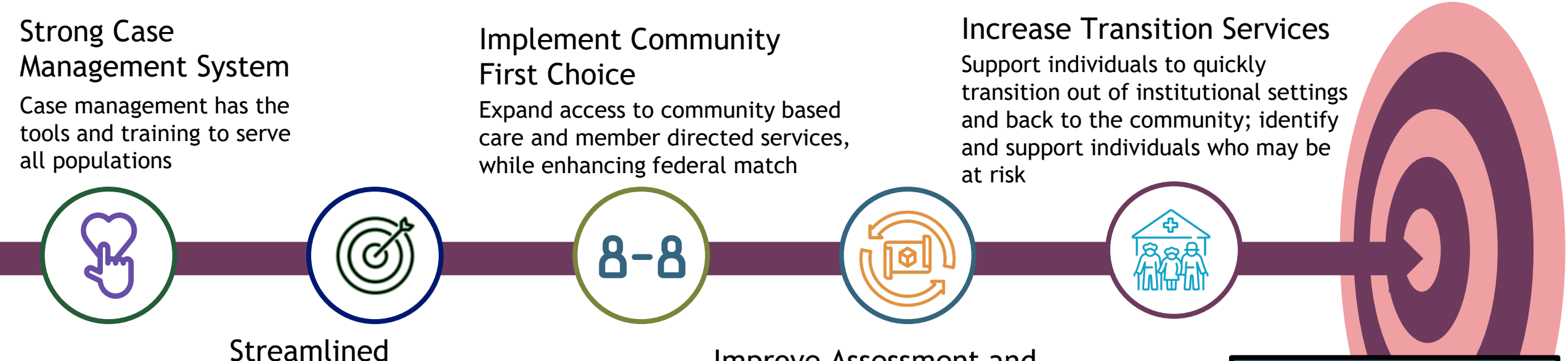
Expand access to community based care and member directed services, while enhancing federal match

Improve Assessment and Support Planning Processes

Implement a new nurse assessor process and prepare for the implementation of the new Colorado Single Assessment tool and Person Centered Budget Algorithm

Increase Transition Services

Support individuals to quickly transition out of institutional settings and back to the community; identify and support individuals who may be at risk



Create a robust system to support a care continuum that provides the right care, at the right time, at the right location for all LTSS members

LTSS Cost Growth Questions 9-14

Question 9, Cost Drivers for LTSS

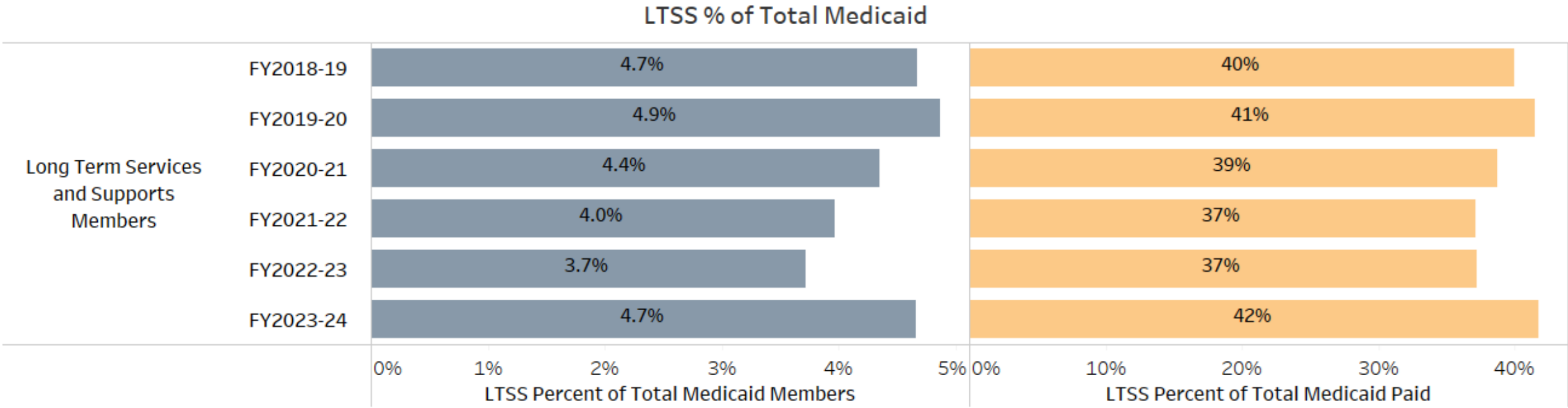
- People with complex needs are living longer
  - The population of adults with I/DD aged 60 and older is projected to double between 2000 and 2030

- The need for long-term care also rises with age
  - An estimated 70% of individuals over 65 will require some form of LTSS, with even higher rates among older age groups

- There is an overreliance on Medicaid
  - Those needing LTSS are more likely to have incomes below the federal poverty level

- Medicaid covers a disproportionate share of these increasing costs
  - Nationally, Medicaid accounted for 61% ($415 billion) of LTSS expenditures in 2022

LTSS Members and Total Cost of Care as a Percent of overall Medicaid



- 4-5% of Medicaid's covered population are people with disabilities, accessing LTSS
- Consumes about 42% of HCPF's claim dollars, up from 40-41% pre-pandemic
- Has a 50/50 match from the fed, similar to children

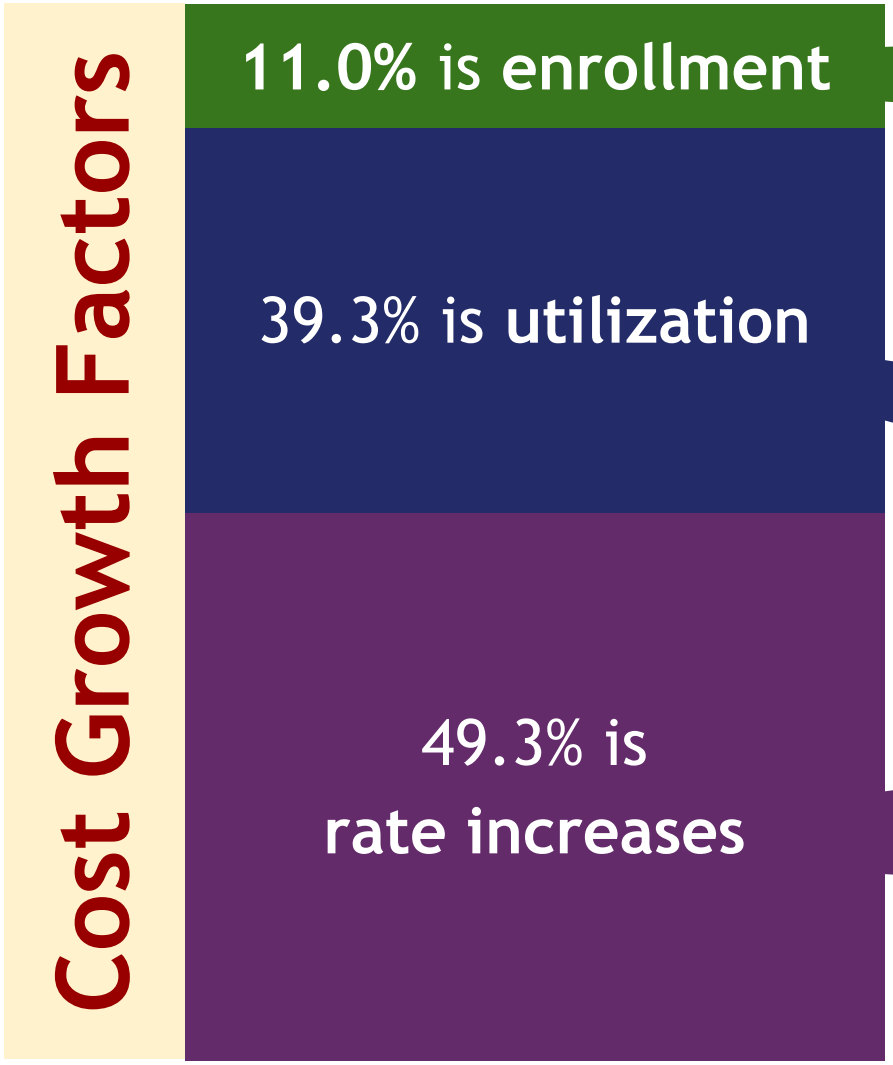
Questions 10-12,HCBS Waiver Program Growth

HCBS Waiver - Children	CLLI	CHCBS	CHRP	CES
Current Enrollment	127	2,265	266	2,842
Waiver Cost/Total Cost per member/year	$4,000/ $153,000	$88,000/ $142,000	$71,000/ $120,000	$31,000/ $126,000
Enrollment Growth FY18-24	-22%	+47%	+808%	+72%

Merging July 1, 2025

HCBS Waiver - Adults	CHI	DD	BI	EBD	SLS	CMHS
Current Enrollment	286	7,951	684	27,404	4,572	3,637
Waiver Cost/Total Cost per member/year	$69,000/ $123,000	$97,000/ $113,000	$75,000/ $91,000	$37,000/ $56,000	$22,000/ $45,000	$16,000/ $36,000
Enrollment Growth FY18-24	+153%	+53%	+49%	+17%	-7%	+6%

Question 10, HCBS Cost Growth: FY20-21 to FY23-24



- Enrollment is skewed towards more complex populations/ expensive waivers (ex.DD waiver avg. cost is $98k vs $36k for EBD waiver)
- JBC added 796 enrollments to DD waiver

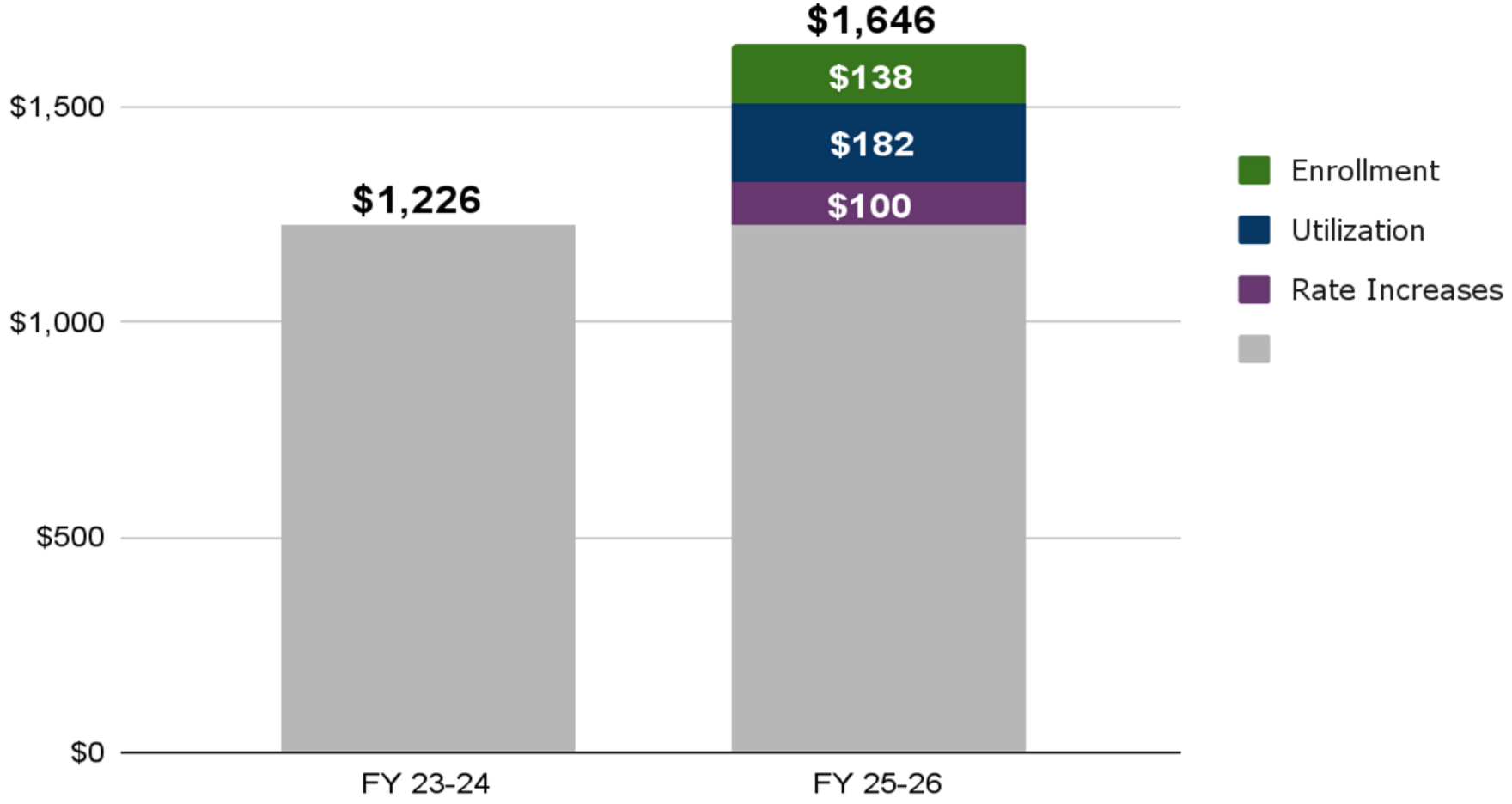
- 70+% of increases due to utilization come from LTHH and IHSS
- Utilization per member has increased 33% for these two services

- LTSS Base Wage to meet local minimum wage adjustments
- Across the board provider rate increases
- Targeted rate increases
- Statutorily required rate increases

Approx 0.4% is due to JBC/Legislative and HCPF benefit changes

Question 13, Projected HCBS Waiver Expenditure Growth

HCBS waiver expenditures, total funds in millions. Projected expenditure growth attributed to enrollment (32.8%), utilization (43.4%), and rate increases (23.7%)

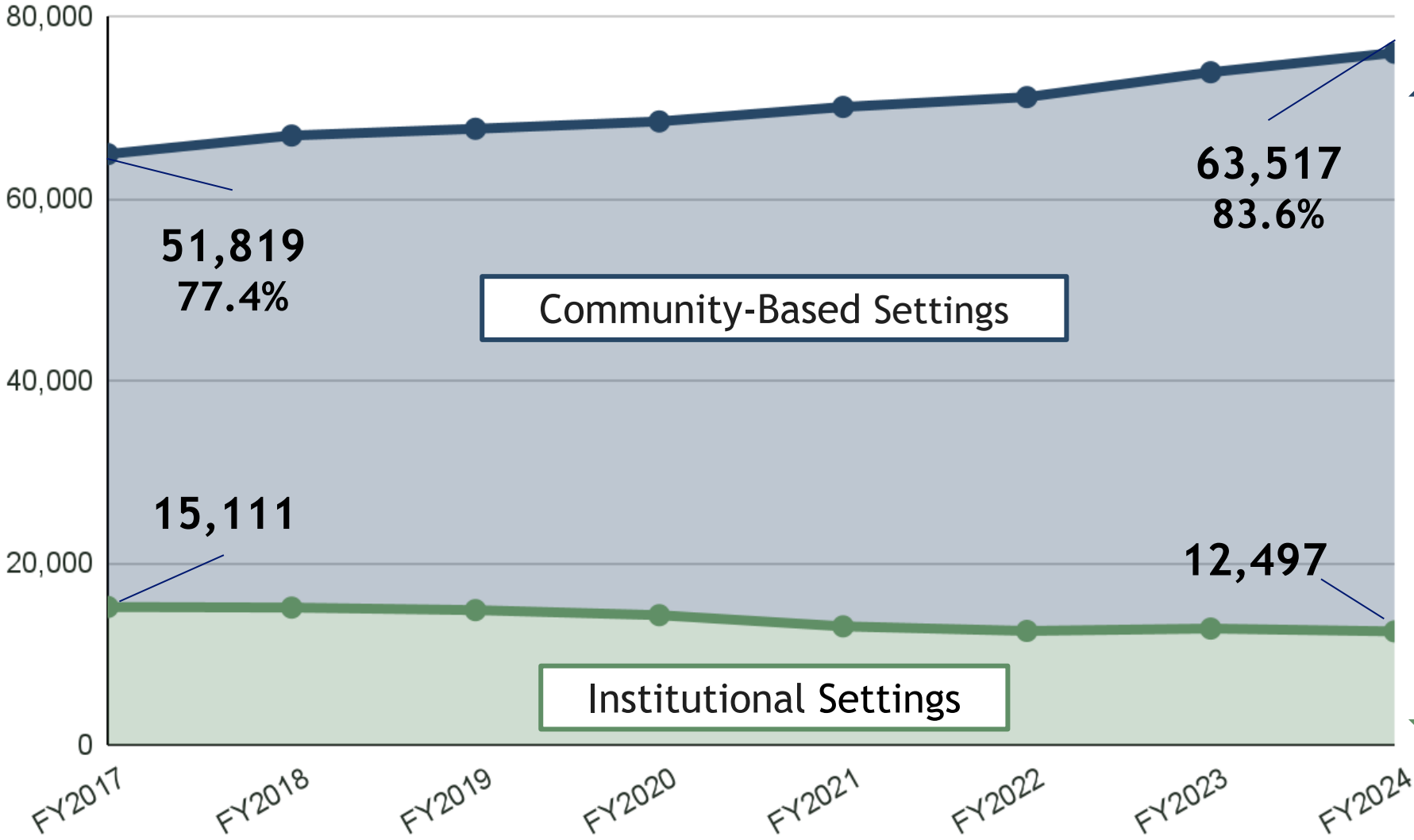


Question 14, Strategies for Sustainable Growth

01	Utilization Management	• Re-Implementation of LTHH PARs in July 2025 • New Nurse Assessor for Skilled Care
02	Federal Financing Opportunities	• Implementing Community First Choice • Money Follows the Person Grant • Leveraging Quality Improvement Organizations (QIO)
03	Keeping People in Community	• R-11 Initiatives • Investing in the Direct Care Workforce • Enhancing Transition Supports and Supporting At-Risk Members

Keeping People in Community as Sustainable Growth Strategy Questions 15-17

Question 15, Community-Based Program Growth

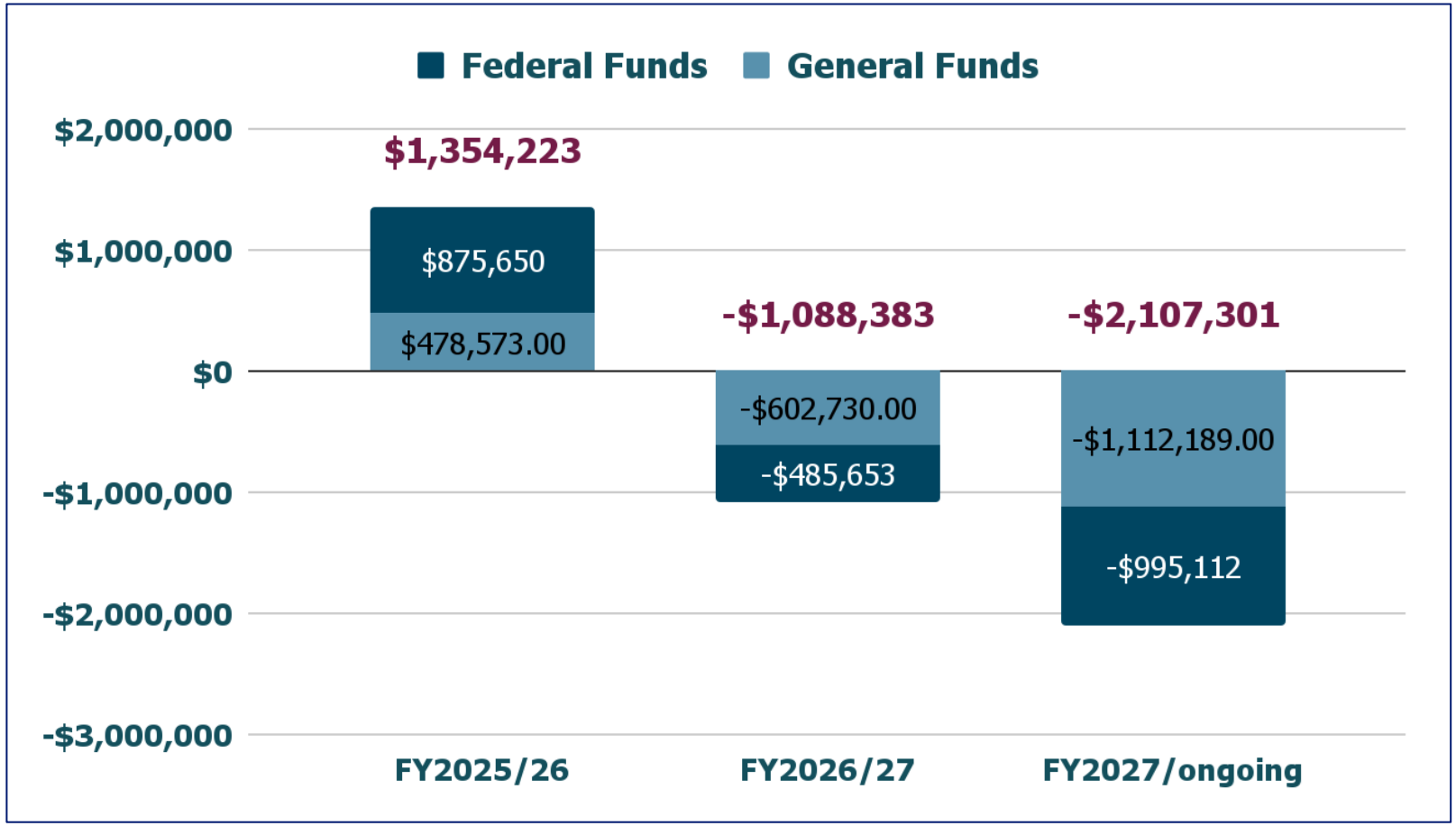


Members in Community-Based Settings
+ 22% growth

Members in Institutional Settings
- 17% decline

Question 16, Good Fiscal & People Policy

$1,354,399 total funds, including $478,573 General Fund, in FY 25-26 to implement **five initiatives** to increase access and add value for community-based services



R-11

- Children's Habilitation Residential Program Group Respite*
- Alternative Care Facilities Tiered Rates*
- Hospital Backup Unit Eligibility Expansion*
- Supported Employment Pilot Implementation*
- Complementary and Integrative Health Waiver Extension

*Indicates anticipated cost savings

Question 17, Delayed Hospital Discharges

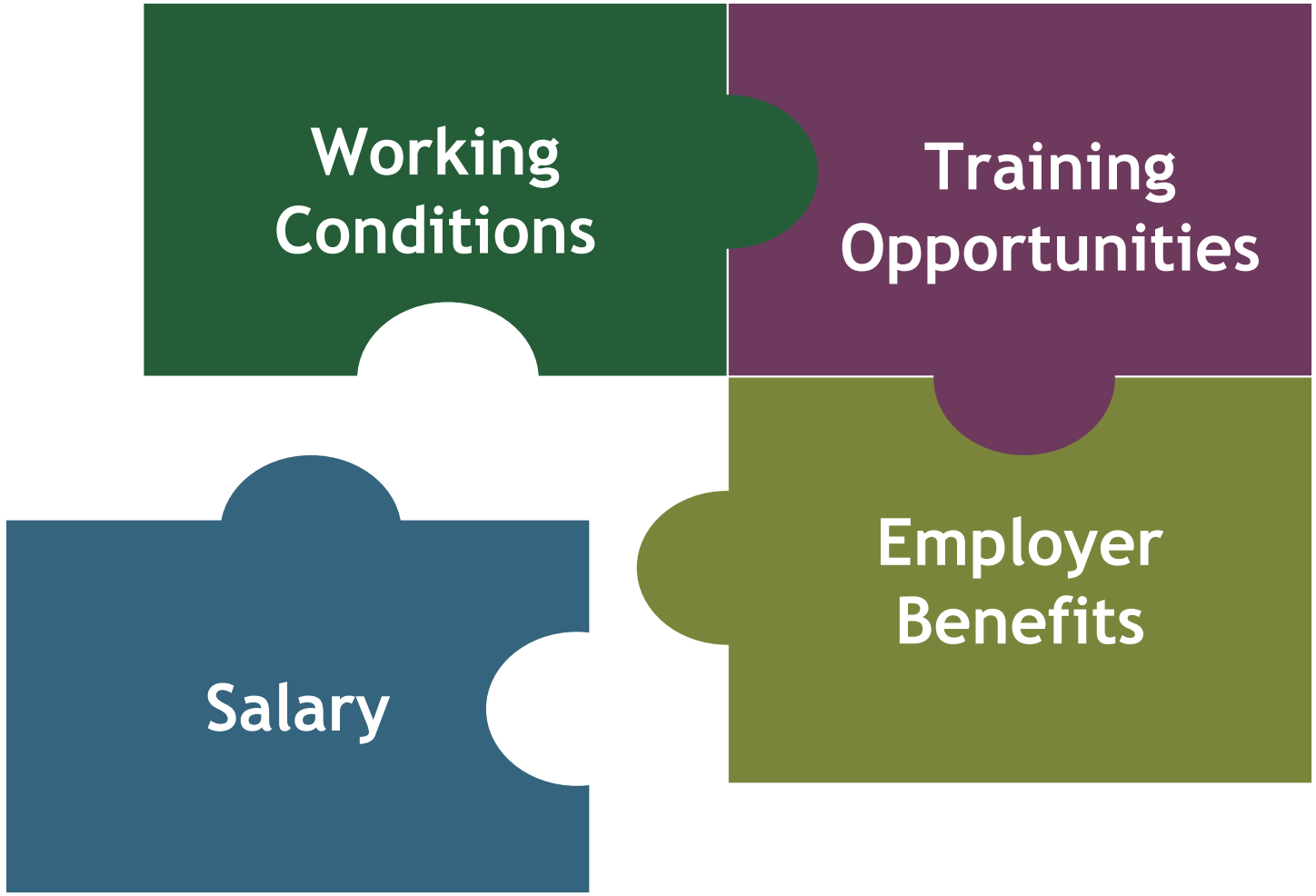
FY 2023 - 2024	76 Children	$5,463,161

Hospital escalation process implemented by HCPF

- Hospitals bring complex cases to HCPF for discharge planning assistance
- Ensures cross-agency collaboration on complex cases
- Cases escalated include complex factors:
  - Family home not suitable or stable for complex health needs of child
  - Family/guardian unable to complete hospital required training for discharge
  - Child needs 1:1 care for mental health needs
  - Child poses a risk to others in the home

Investing in Workforce to Keep People in Community
Questions 18-20

Question 18-19, Healthcare Workforce



Competitive wages are one piece of the puzzle to ensuring a strong nursing and direct care workforce for Long-Term Services and Supports

Question 20, Direct Care Workers Wages

$683 million investments over last 4 years

Wage Type	2022^	2023	2024
State Minimum Wage	$12.56	$13.65	$14.42
HCBS Base Wage	$15.00	$15.75	$17.00
HCBS Average Ending Wage	$17.48	$18.66	$19.23*

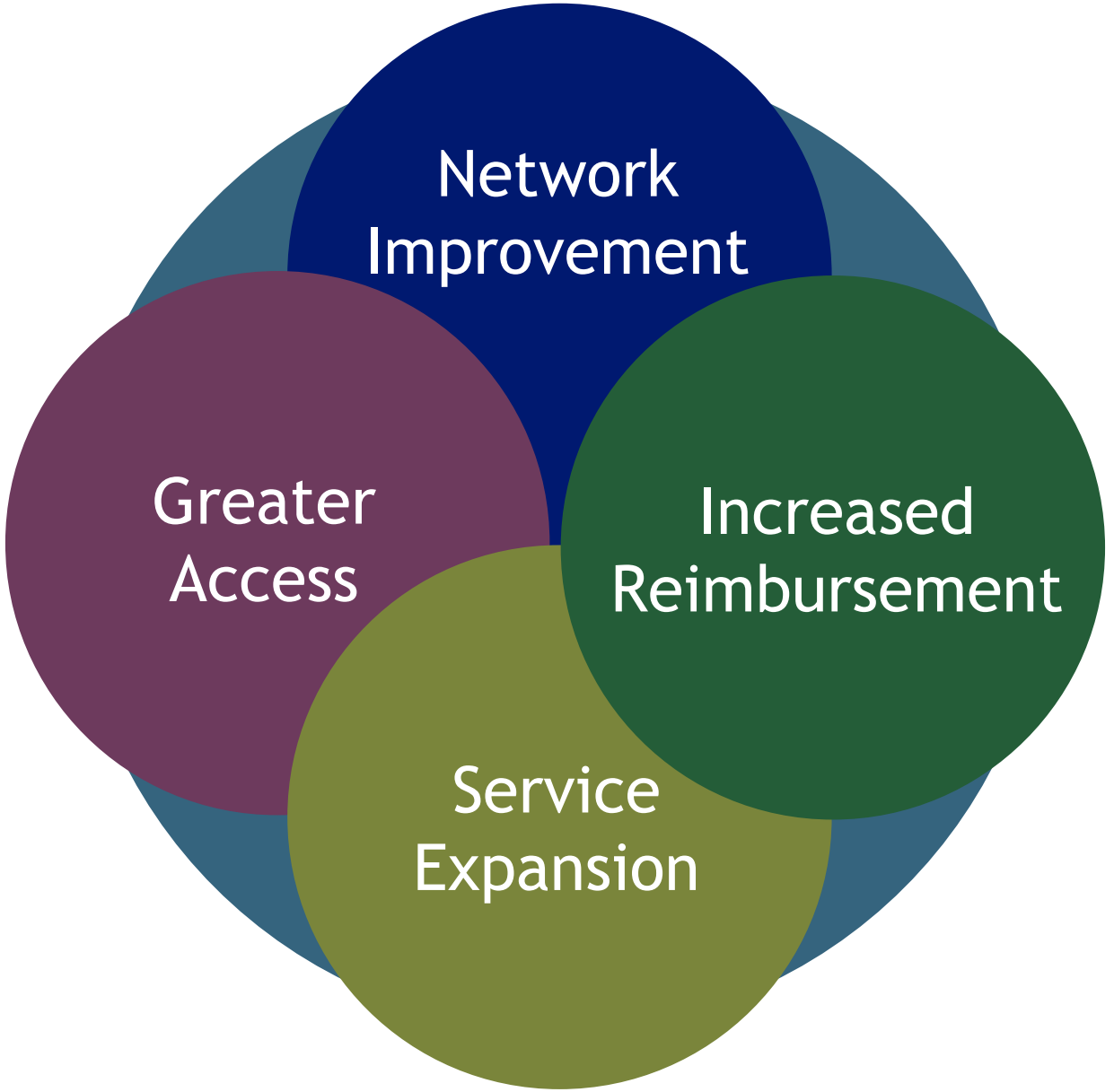
^Pre-base wage requirements show average was $12.41 statewide
**Preliminary wage -Data continues to be collected and aggregated*

Lunch Break

Behavioral Health

Cristen Bates, Behavioral Health Initiatives
and Coverage Office Director
Robert Werthwein, Senior Advisor for Behavioral Health & Access

Pulling Every Lever



Last 4 years:

95% increase in RAE contracted providers

41% increase in member access

113% ($191M) increase in funding for independent providers

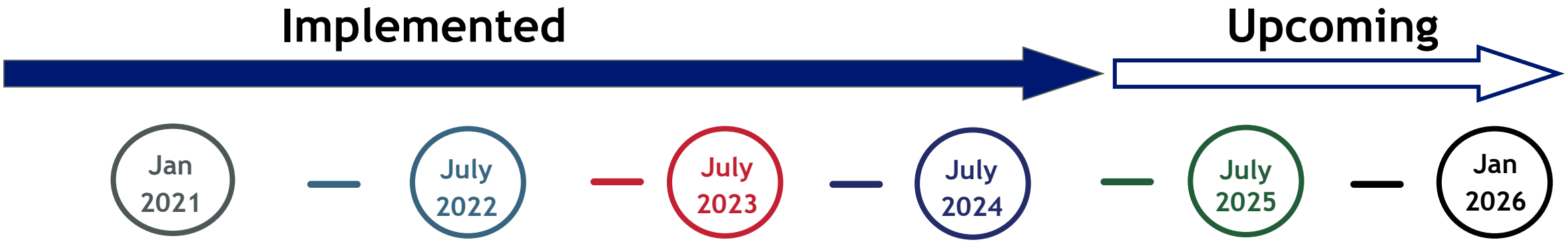
$1.1 Billion total Medicaid BH expenditure FY23-24

LEGISLATIVE LED IMPROVEMENTS

38 Bills in 4 Years Directing Medicaid in Behavioral Health

- Strengthening and Expanding Safety net
  - New provider types, new contracts, new payment models
  - CCBHC Demonstration Planning Grant
- Establishing System of Care for Children and Youth
  - Adding BH to CHRP waiver
  - Enhanced rates for high need kids
  - No longer requires BH diagnosis
  - Assessments, intensive care coordination, workforce development
- Covering the full continuum of SUD care as of 2024
- Peer recovery support services, keeping people well
- Increased access to medication assisted therapy
- Implemented Mobile Crisis and Secure Transport crisis to reduce law enforcement and ED usage
- Provider trainings on billing, practice improvement

Expanding Benefits and Eligibility



Jan 2021

Substance Use Disorder Residential and Detox (1115 Demonstration Waiver)

July 2022

Recovery Support Services Organizations

July 2023

Secure Transport

Mobile Crisis Response

July 2024

Partial Hospitalization Program

PPS Payments, Enhanced Rates

July 2025

Criminal Justice Reentry

Mental Health Inpatient >15 days

High Fidelity Wraparound

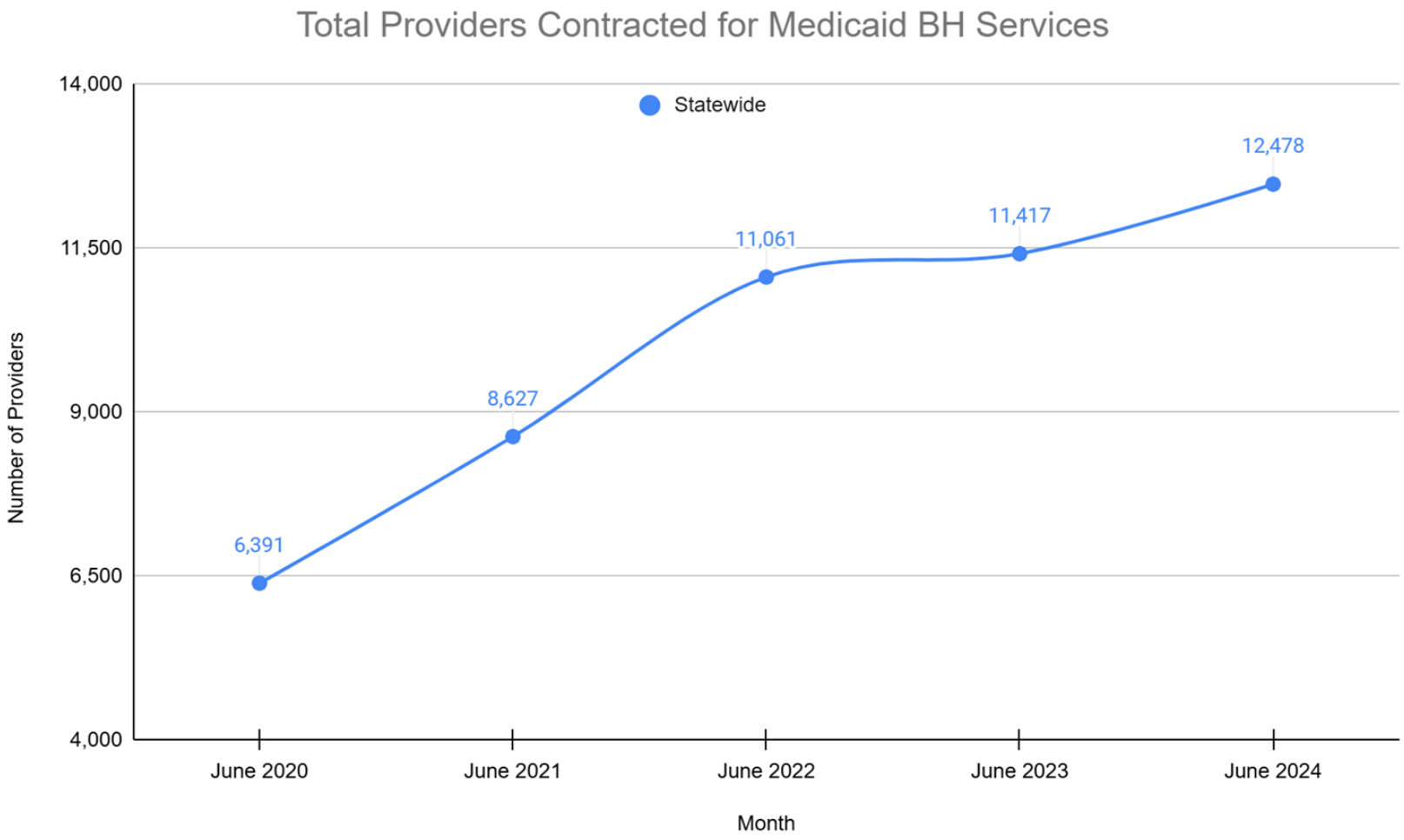
BH in CHRP

Jan 2026

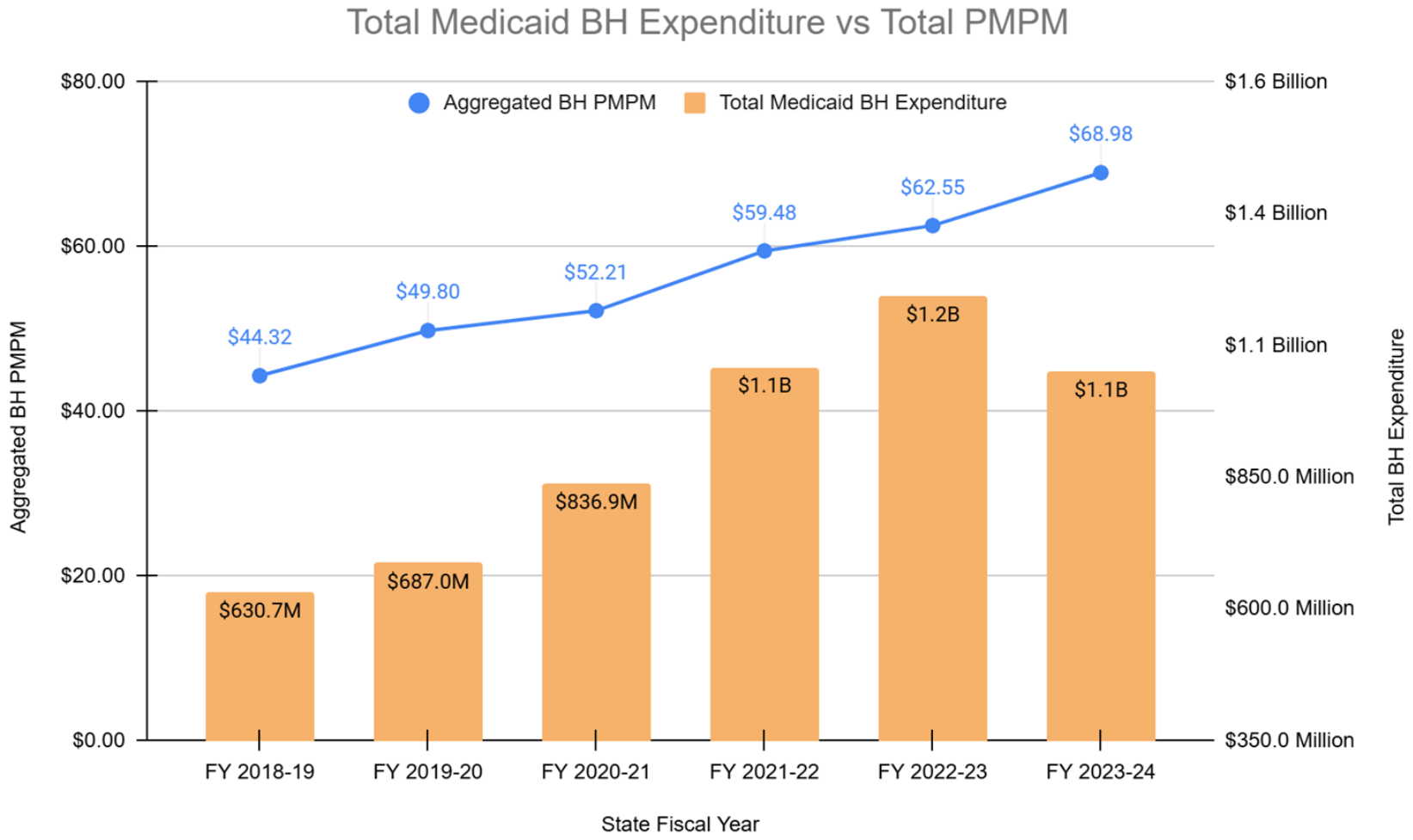
Move to Comprehensive 1115 Waiver

CJ Reentry in Jails

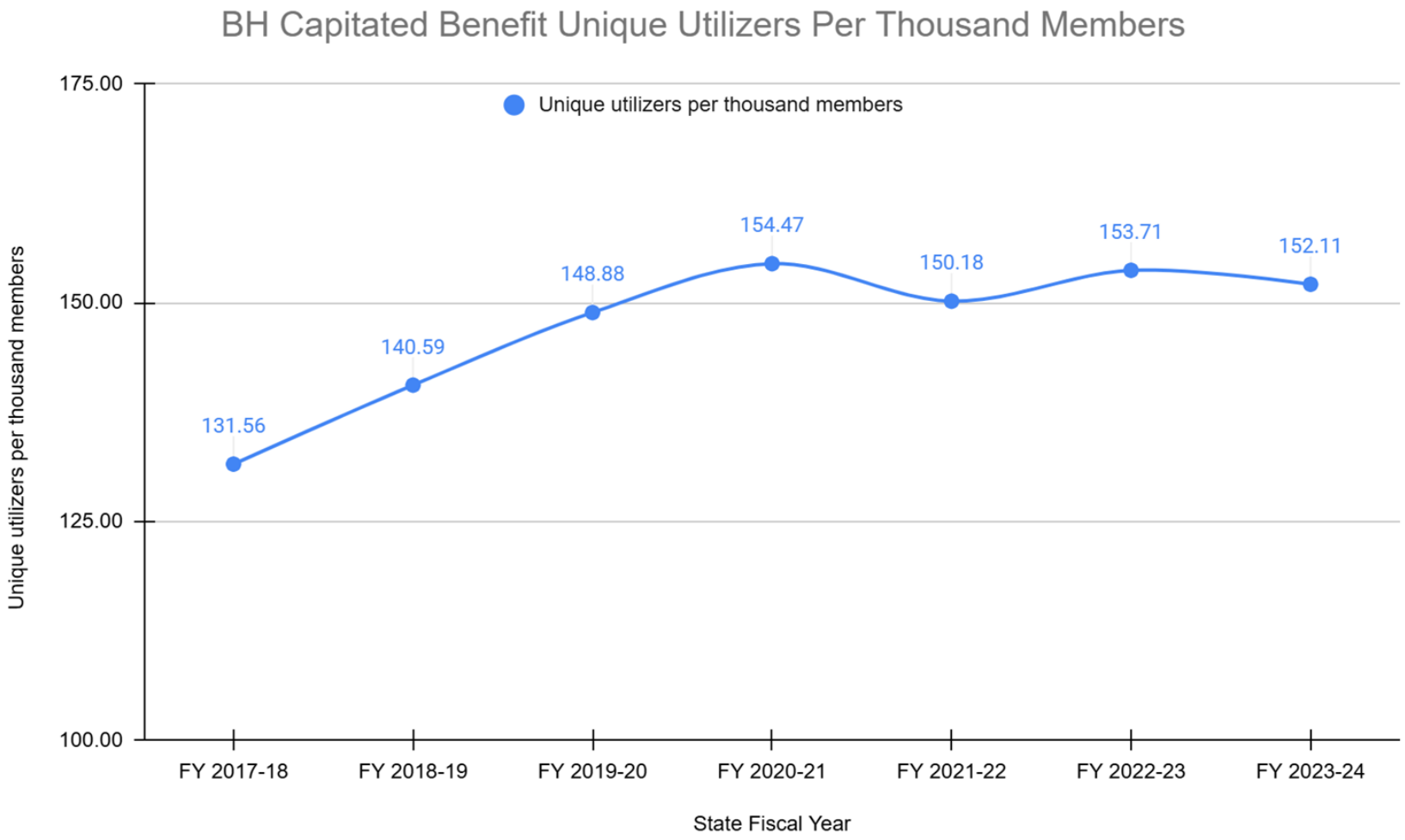
Question 21-23: BH Network Providers



Question 21-23: Total Medicaid BH Expenditure



Question 21-23: BH Capitated Utilization



INVEST AND BUILD

American Rescue Plan Act (ARPA)

- $139M in HCBS ARPA
- Support for AI/AN, children and youth, rural health, indiv. with disabilities
- 283 BH community partner grant projects statewide
- 250 sites expanded integrated care, intensive outpatient services
- Workforce development, training and technical assistance
- Spending complete for all project ending 12/31/24

EXPAND BENEFITS

1115 Waiver

- Criminal Justice Reentry services for incarcerated people
  - Reimbursement for assessments, care coordination, MAT (90 days prior to reentry)
  - State/local partnerships
- Expanding the Mental Health Inpatient coverage past 15 days
- Health Related Social Needs
  - Supportive Housing
  - Nutrition Supports

Behavioral Health Initiatives and Coverage Office & Collaboration with the Behavioral Health Administration: Questions 24-25

Question 24: Collaborative Policies

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

- Safety Net Reform
- Managed Care Entities
- Colorado Crisis System
- Substance Use Benefits
- CCBHC Grant
- Children and Youth
- Provider Training
- Operational Partnerships
- Peer and Recovery Services

Question 25: Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office (BHIC)

Formed to meet the growing demand:

- Increased number of state-based transformative initiatives, requiring coordination and collaboration across BHA and state Departments
- State required expansion of BH benefits requiring federal approvals, monitoring and oversight, new provider types and new payment models.
- ARPA funding, over $550M, with over $130M in projects and funds focusing exclusively on behavioral health

Better alignment with behavioral health-related work

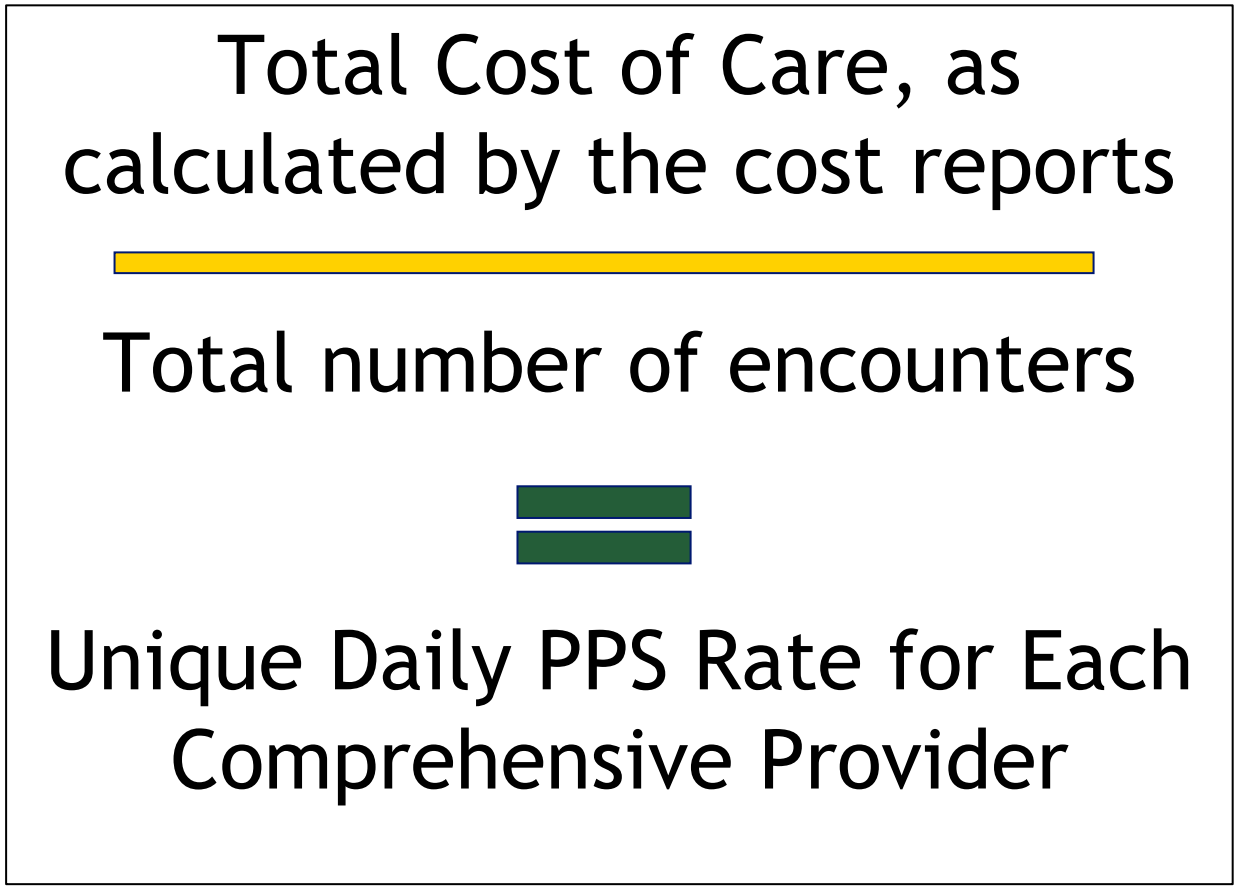
Accountable behavioral health leadership within HCPF

More effective structure and efficient use of staff resources

ZERO new FTE were added to form the BHIC Office

Prospective Payment System: Questions 26-28

Questions 26-28: Calculating the Comprehensive PPS



- Service definitions align with statute and BHA rules, CCBHC
- Safety Net Cost Reports used to gather costs for services across all payers
- Daily Encounters are based on the approved BH codes
  - Incentives and Risks of Daily v Monthly
  - Prioritizing complex needs
- PPS trended forward, annual increase built in

Questions 26-28: PPS: Creating Sustainable Funding

PPS Goal: Create sustainable funding for actual costs to operate safety net BH clinics

Covering the Cost of Operation…

Including:

- Personnel costs: Salaries, training, employee benefits of direct program staff and indirect administrative staff.
- Client-related costs: Medical supplies; payments to other service providers; transportation, **uncompensated care**
- Occupancy costs: Rent, utilities
- Operating costs: Technology, data, licenses, insurance

…With Accountability

Limits on payment for:

- Limitations on salary for execs, alcohol and entertainment
- Lobbying, fundraising, legal fees
- Unfulfilled contracts

BHA standards for providers:

- Serve priority populations
- No eject / no reject

Youth Systems of Care: Questions 29-34

Question 29: Community-Informed System of Care

Community Insight

- 35 sessions across the state, Live and virtual, population focused
- Surveys for input
- Stakeholder Report

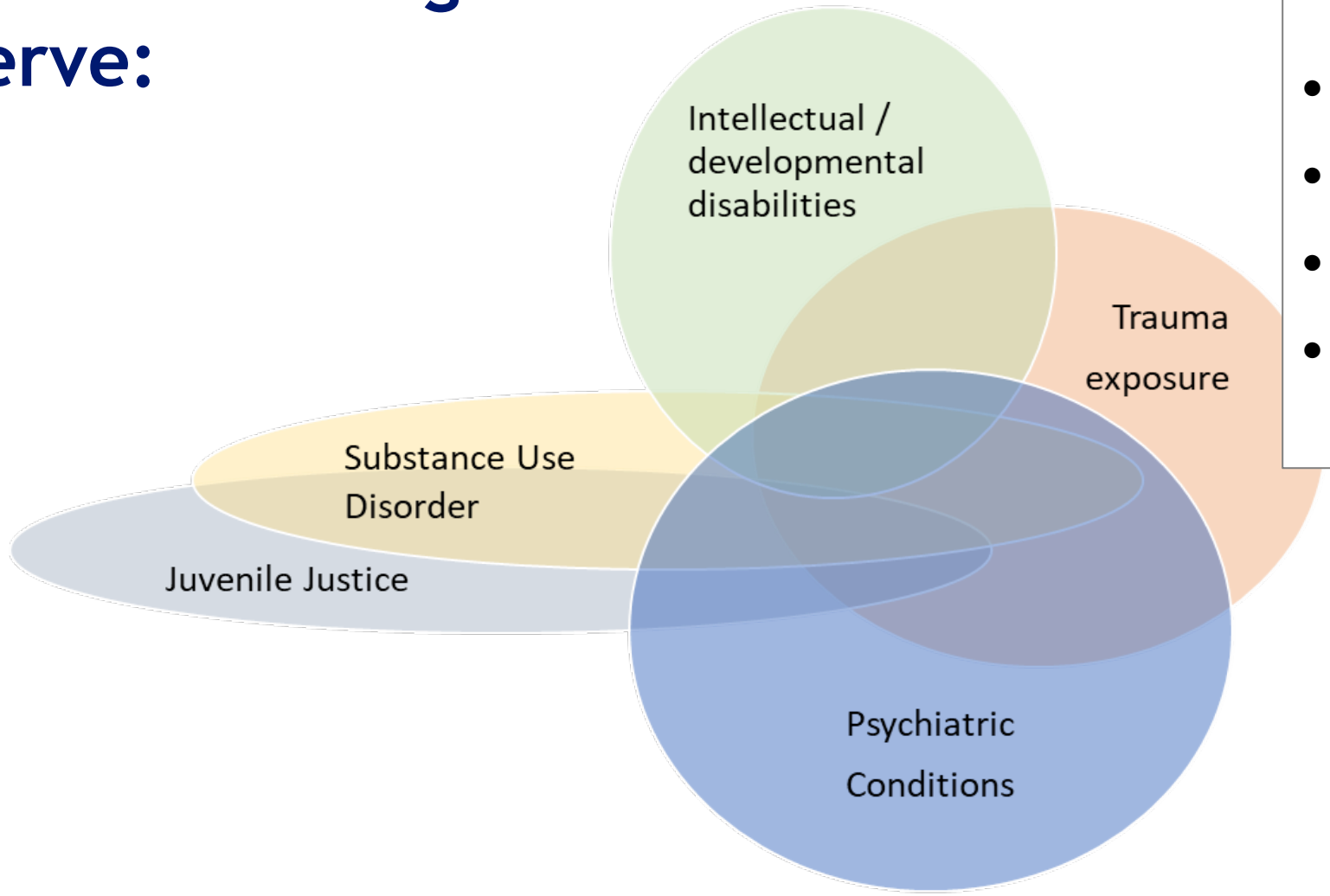
Leadership

- Lived Experience Advisory Committee
- Implementation Advisory Committee
- Statewide Leadership Advisory Committee
- State Plan design working group

Communications

- HCPF_MSOC@state.co.us
- Website with all settlement and project materials

Question 30: Who system of care is designed to serve:



Settlement Agreement Specific

- Under the age of 21
- Medicaid-enrolled
- Has a mental health need
- Level of current functioning requires intensive services

What is System of Care:
The whole is greater than the sum of parts

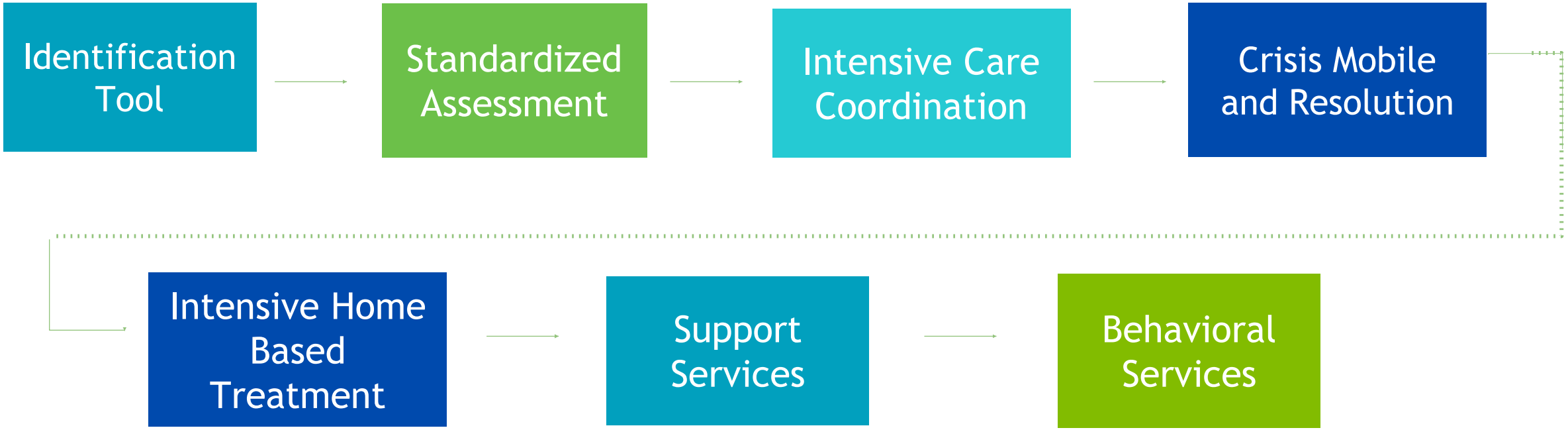
Care coordination in Current System

Well intended, but has minimal quality outcomes for children with complex needs

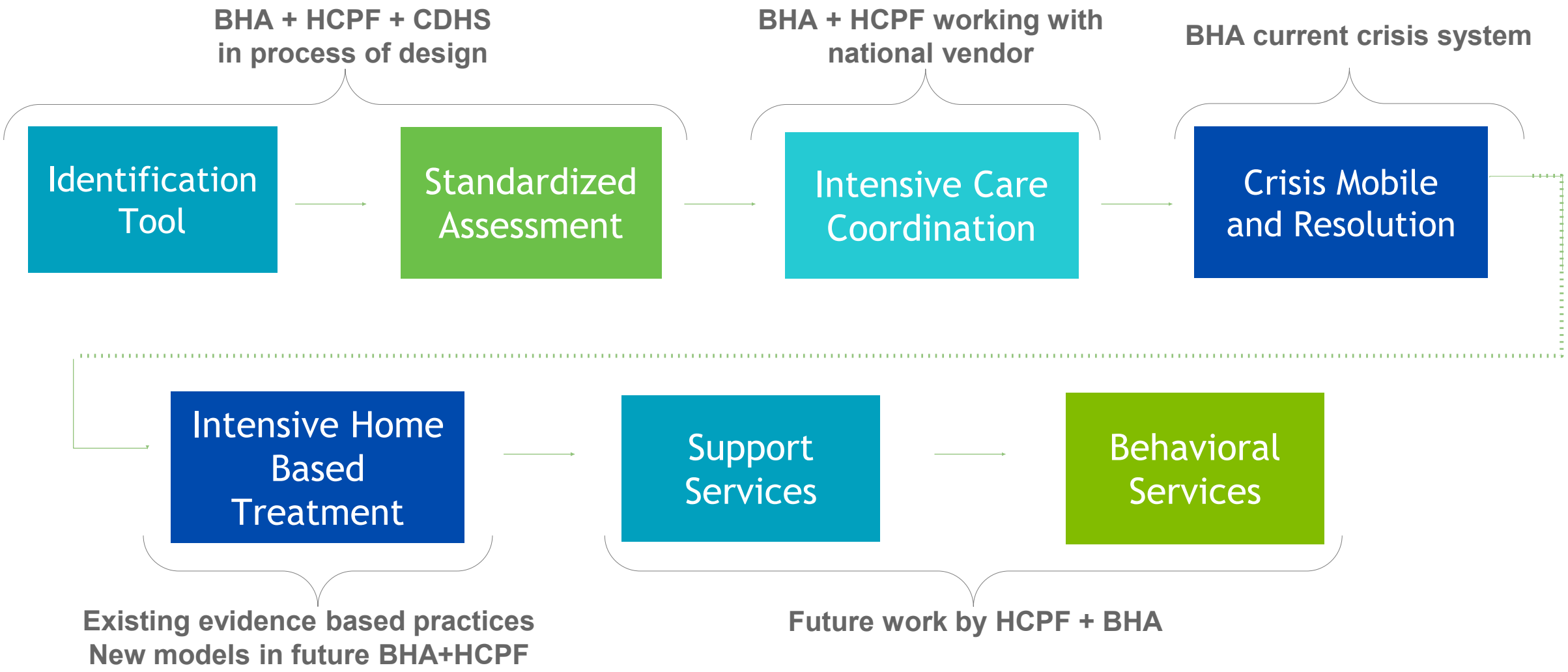
Care coordination in System of Care

Have hands-on and in-depth coordination of intensive treatment and support services = strong quality outcomes

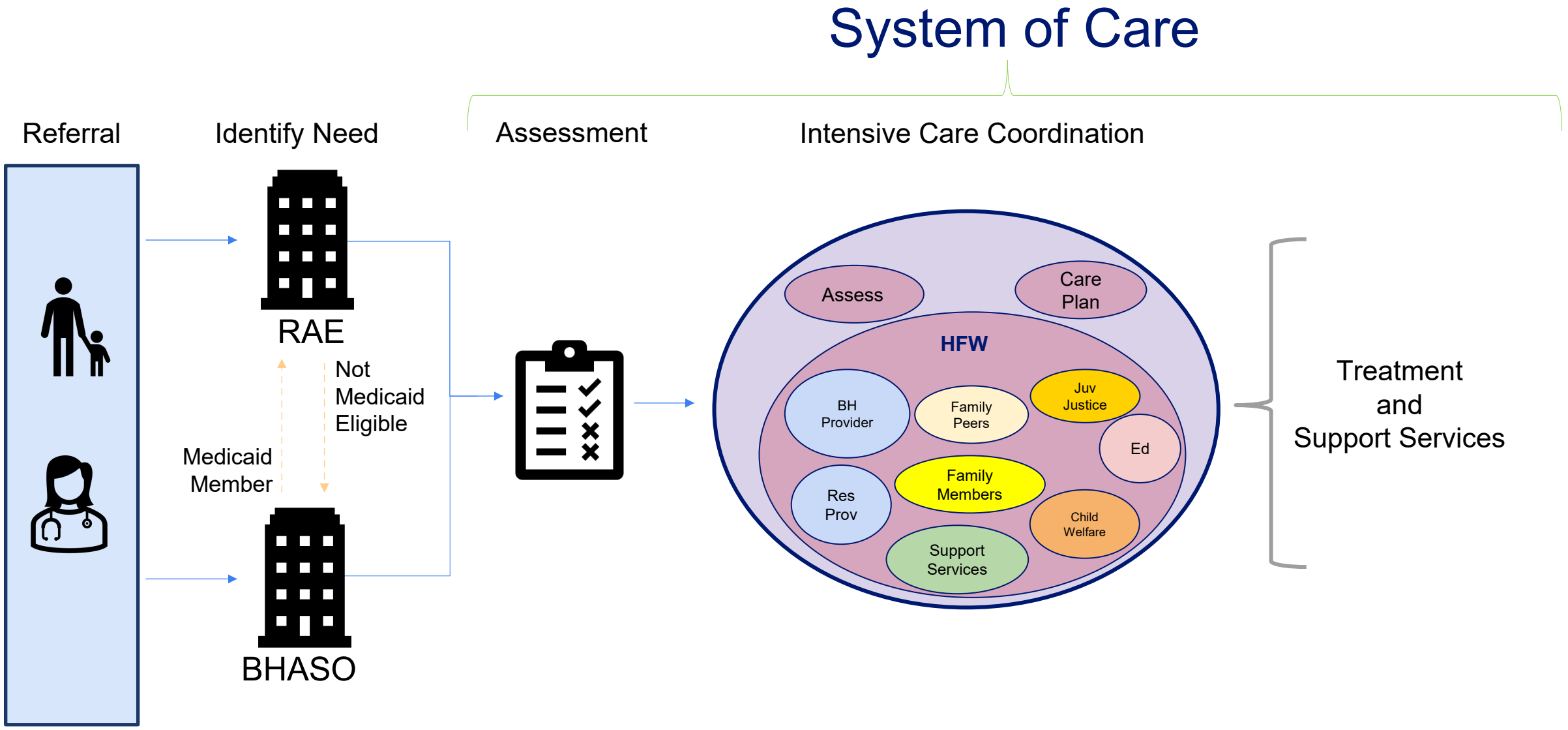
Question 31: System of Care Has 7 Key Parts



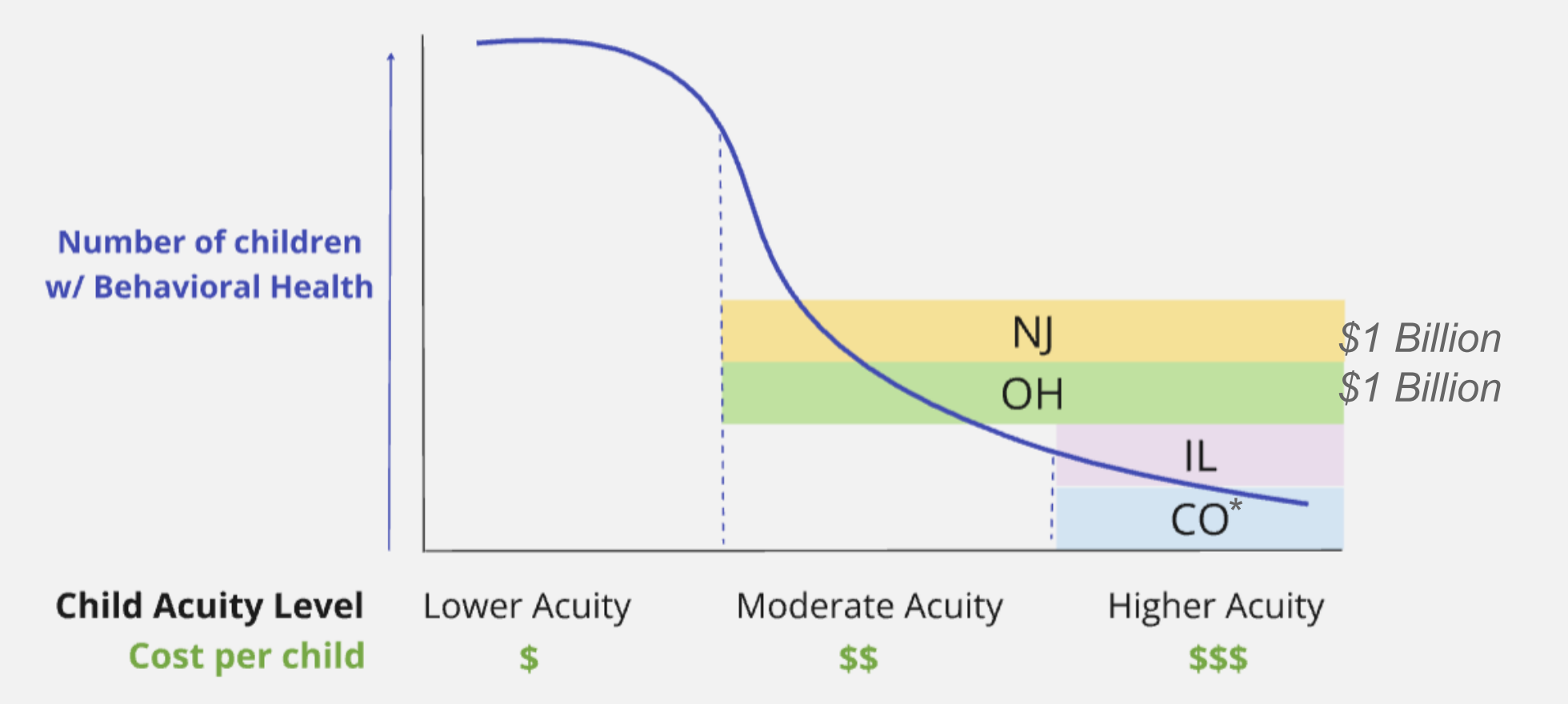
Question 31: System of Care



Question 32: No Wrong Door



Question 33: System of Care Population and Cost (Total Funds)



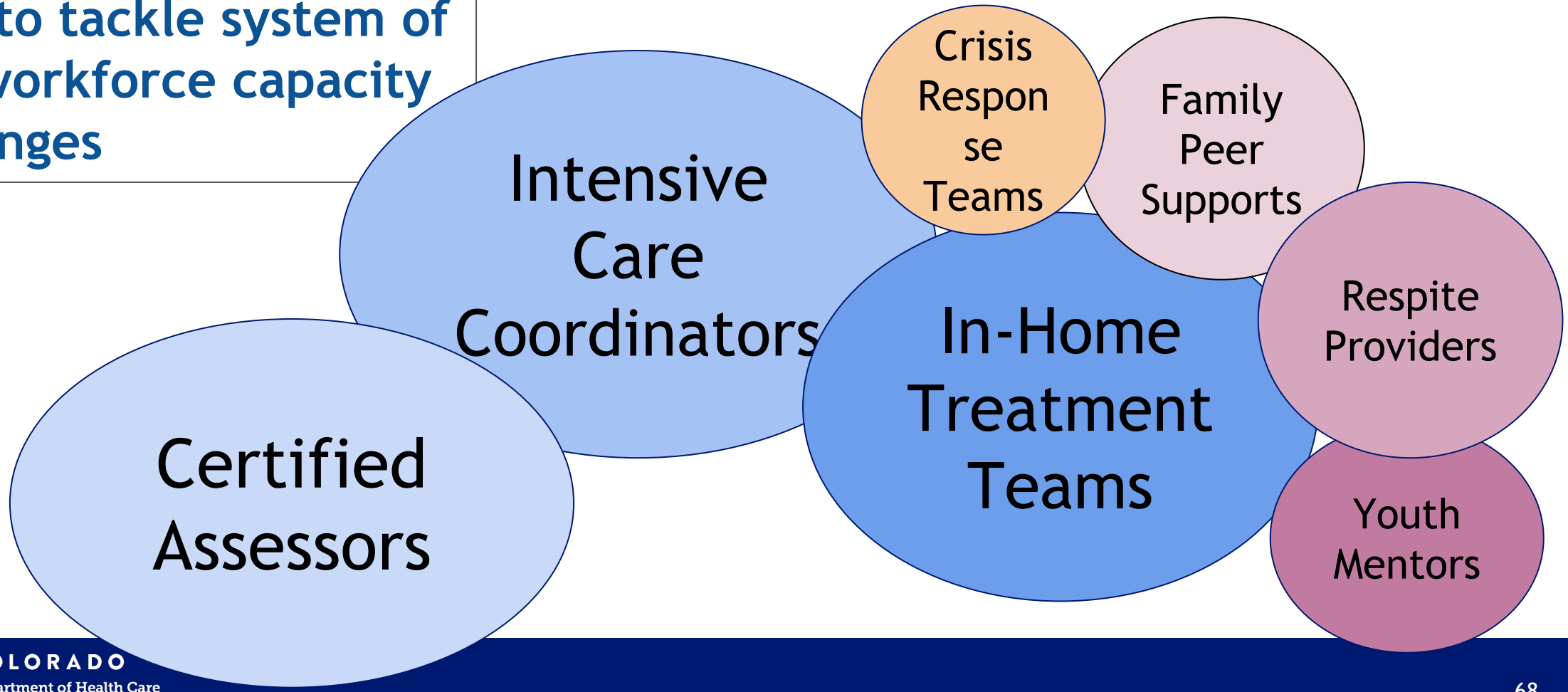
* Still in conversations with plaintiffs on defining the exact scope of population.

Question 33: Using Existing Resources

Existing Resources
Existing benefit covering outpatient, inpatient, residential, targeted case management, etc
Oversight and accountability structure of ACC 3.0
High Fidelity Wrap SB 19-195
High Fidelity Wrap HB 24-1038
Assessments HB 24-1038
Offset in cost from immediate Reduction in Residential Stay
Offset in cost from long-term reduction in emergency room, residential and inpatient stays
Merging BHA and HCPF resources and efforts for provider training

Question 33: System of Care Workforce

Joint effort by BHA + HCPF to tackle system of care workforce capacity challenges



Integrated Behavioral Health Services: Questions 35-38

Question 36: Progress of Integrated Care Grant

100%
contracted as of Dec 18, 2024

44.6%
Funds spent, to be fully complete by Dec 31, 2026

18
Pediatric sites

4
Comprehensive Providers

13
FQHCs

141
current clinical sites

32
counties

No. 1 request for funds
hire licensed BHPs

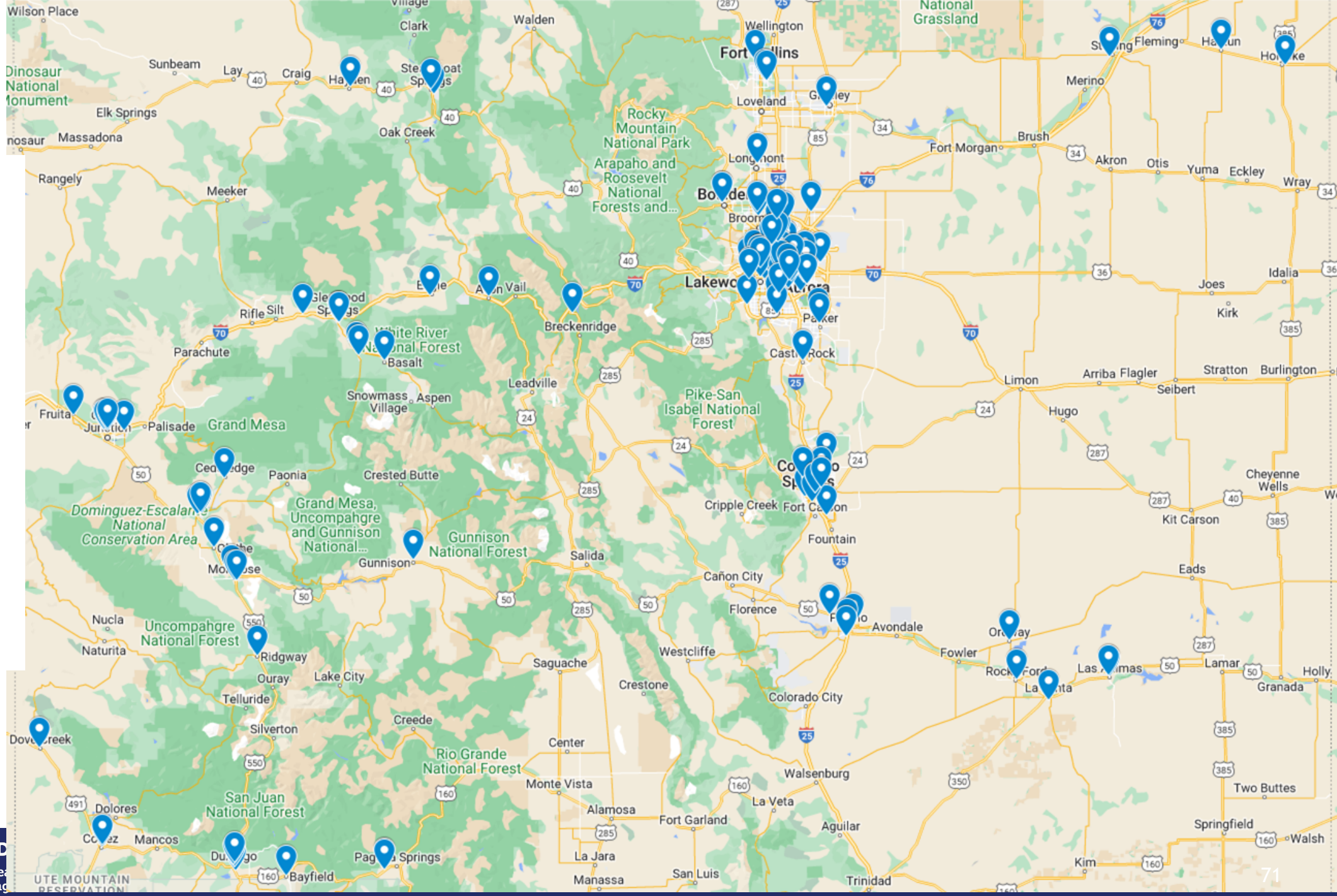
15 SUD sites
5 newly implementing
10 expanding services

Other funding uses include learning integrated care workflows, increasing in-person behavioral health, telehealth, and psychiatric care team, updating EHR, build out office space.

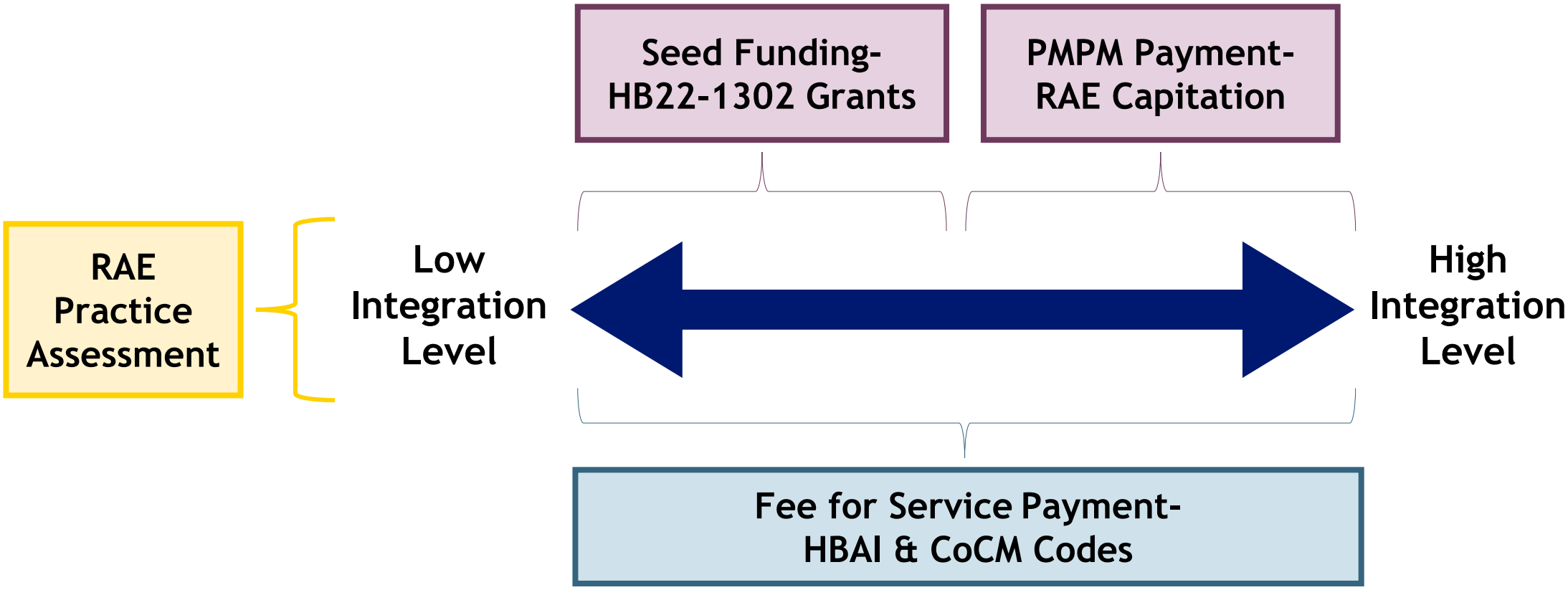
60%
Expanding Behavioral Health Services

39%
Newly implemented Behavioral Health Services

Question 36: Integrated Care Grantee sites



Question 37: Sustainable Funding from Grants to Reimbursement



Question 38: Care Models

STBH

Short-term Behavioral Health Benefit

- Traditional psychotherapy codes for individual members and family (45 and 60 minute session)
- Co-location vs Integration
- Limited 6 visits
- Low utilization

HBAI

Health Behavior Assessment and Intervention

- Brief assessments, referrals, and intervention (15 min)
- Providers prefer for team-based, whole person interventions
- Unlimited number of visits

CoCM

Collaborative Care Management Model

- Increases access to psychiatric care and addiction medicine
- Builds capacity of primary care teams, best use of limited workforce
- Unlimited number of visits

Reduction Options: Questions 39-46

Question 39: Reduction Options - Impact Trend

The JBC asked HCPF to respond to reduction ideas as outlined in the briefings and partner during this difficult budget year. To that end, the Governor's supplemental and budget amendment package released on January 3 has suggested a set of reductions for HCPF. This is in addition to the reductions requested in R-9, "Provider Rate Adjustments," R-15, "Pharmacy MAC," and R-16, "Medicaid Financing Reductions."

Bucket	Item
Administrative Costs	Increase prepayment reviews
Benefits	Repeal HB 24-1038 High-Acuity Crisis for Children & Youth; halt prenatal coverage of choline supplements per SB 24-175; reinstate PARs for antipsychotic drugs per SB 24-110; halt reimbursements for community health services; reinstate an annual cap on the adult dental benefit; eliminate the adult denture benefit; halt reimbursements for remote patient monitoring per SB 24-168; halt coverage of CGM expansion per SB 24-168; cap churn enrollments on the DD waiver; 1% reduction to state-only programs for people with intellectual and developmental disabilities

Question 39: Reduction Options - Impact Trend, Continued

Bucket	Item
Eligibility	Halt Medicaid and CHP+ look-alike for children lacking access due to immigration status, per H.B. 22-1289; halt continuous coverage for children to age 3 and people to 1 year after incarceration per HB 23-1300; eliminate or cap the reproductive health for individuals not eligible for Medicaid program; eliminate CHP+ coverage of children and pregnant adults from 206% to 265%
Provider Rates	Eliminate the statutory 1.5% increase for nursing facilities; 1% reduction in provider rates; reduce dental, pediatric behavioral therapies, and rates above 95% of Medicare by 1%

Question 39: Reduction Options, Do NOT Impact Trend

Bucket	Item
Administrative Costs	Reduce contract services; reduce funding for OeHI; eliminate APCD; eliminate county incentive program; 5% reduction to OCL personal services; reduction to OCL personal services to eliminate GF in excess of federal match
Financing	Convert nursing home provider fees to enterprises; redirect HAS Fee from supplemental payments to offset GF
Grants	Halt rural grants for remote monitoring tech per SB 24-168; eliminate training grants for screening and interventions related to substance use; eliminate family medicine residency training program funding; eliminate supplemental payments to Children's Hospital; eliminate grants for dental care for seniors who do not qualify for Medicaid

Questions 40-46
Reduction Options, Continued

Eligibility, R7 County Administration and CBMS: Questions 47-61

Question 47: Prioritizing County Infrastructure - People and Systems

SB 22-235 report to JBC Nov. '24

- New funding model, county workforce to match need and higher salaries to improve county ability to hire/retain
- Intelligent Character Recognition and Interactive Voice Response technology
- Policy guidance improvements
- Service delivery standards and aligning administrative requirements
- Pool hours and supports for training and complex cases

FY 2025-26 R-7 Budget Request

- $38.2M to address above plus CBMS and escalations support

Joint Agency Interoperability Co-Created with Counties

- Unified work management system across counties
- Unified document retention system across counties
- ITN active thru mid Oct. (implementation begins 26/27)

Reducing county workload and improving accuracy

- Improving renewal ex parte automation, PEAK member digital tool capabilities and utilization, and PEAKPro provider/community partner elig. tool

CBMS Strategy and Vision Co-Created with Counties

- Improves CBMS support system for workers and members (target completion: June 2025)

Improve member correspondence accuracy, readability

- Addressed audit findings by revising CBMS letters
- Improvements continue

Critical Priority: Addressing/Mitigating System Downtime!

Modern CBMS Ecosystem and Current Add'l Opportunities

- CBMS screens/interface are built on Salesforce. Sept 2024 migration to Hyperforce.
- CBMS eligibility determination uses Corticon rules engine, updated 2023. 2025 upgrade to Micro Services.
- Amazon Web Services (AWS) cloud data storage in the cloud. Regular upgrades.
- Member facing online application and benefits portals: PEAK uses Lightning, which is Salesforce's latest framework. 2023 update. MyCO/MyCOBenefits app to manage food and cash assistance benefits via mobile devices is built on React. Yearly updates.
- PEAKPro simplified eligibility functions. Enhancements in three phases 2023-2024.
- **Current Opportunities/Focus:**
  - Addressing system downtime, in partnership with OIT, HCPF, CDHS, counties.
  - Don't have enough funding for CBMS pool hours or staff to keep pace with state work (ie: bills, county requests) or current and future federal requirements (175-250k pool hour funding shortfall).

Question 48: Eligibility

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

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

Question 49: No Wrong Door

- Certified Application Assistance Sites (143)
  - Community organizations, some co-located at hospitals/clinics, some also marketplace assisters
- County Human Services (59*)
- Eligibility Application Partners (8)
- Medical Assistance Sites (3)
- **Expansions:**
  - Presumptive Eligibility hospitals in 2026 (currently 31, but limited to pregnant women and children under age 19)
  - Partnerships with counties and UCHealth example
    - Trainings and toolkits for providers on use of PEAK

*There are 64 counties, Rio Grande and Mineral, Gunnison and Hinsdale partner as eligibility sites.

R7 | County Administration and CBMS Enhancements

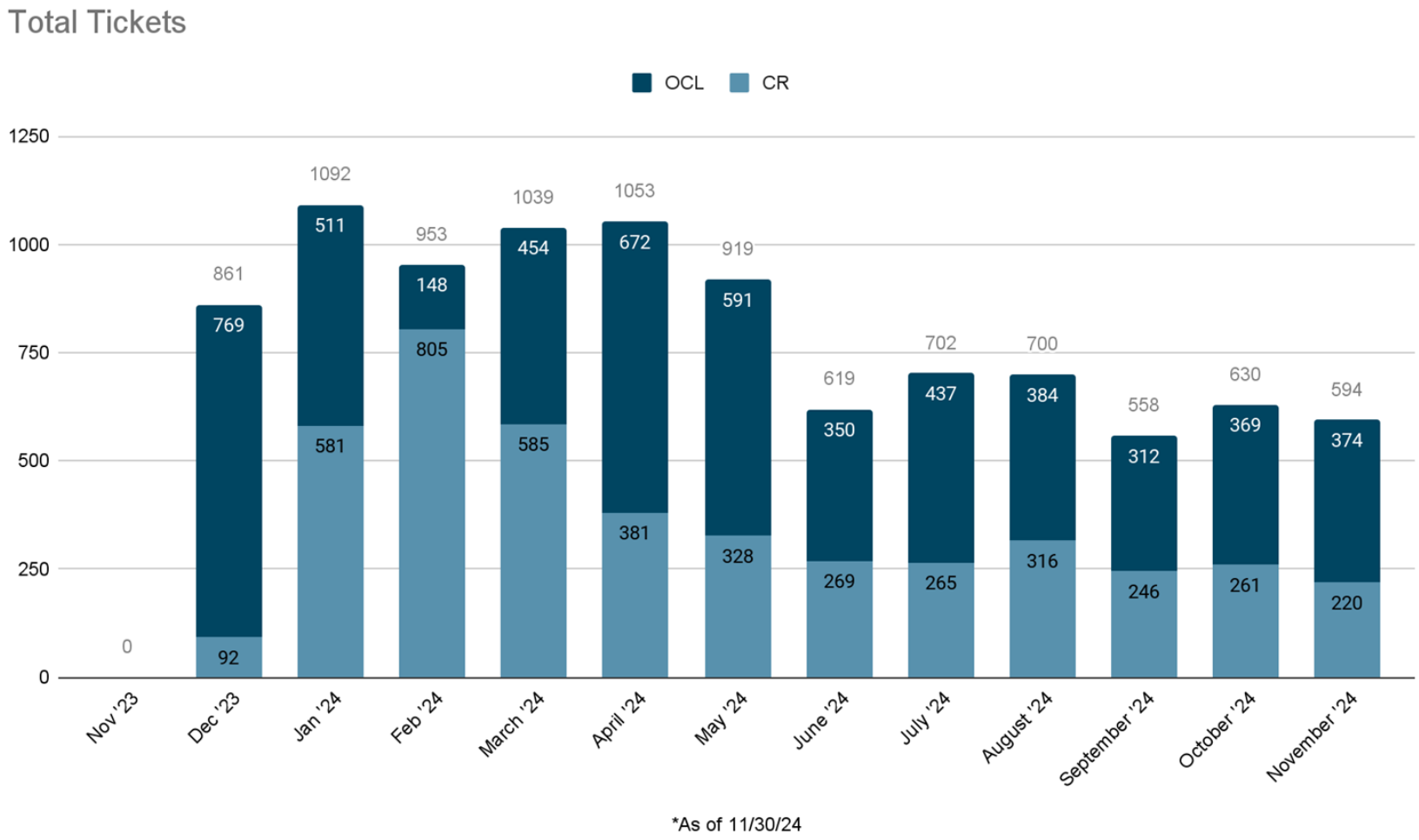
- $25.2 million investment (HCPF R-07 + CDHS R-01) in the county workforce that supports higher wages and more eligibility staff, call center agents and customer service staff
- 10% increase in HCPF pool hours for CBMS for projects that help members retain coverage, support counties, and streamline system processes
- Interactive Voice Response (IVR) call system for members to access information about eligibility and reduce county call center volume
- Permanently funding HCPF's county escalation process
- Implementing an automated solution called Program Area Natural Dialogue Assistant (PANDA) for county staff to navigate and get support on eligibility policies
- Funding an expansion of intelligent Character Recognition (iCR) that will reduce manual data entry from documents received for eligibility.
- Funding to replace specific CBMS software technology that causes delays in county processing
- Funding additional, future SB 22-235 Year 2 model updates that will allow HCPF to set caseload-to-staff ratios for Long Term Services and Supports (LTSS) cases and explore funding needs for dedicated LTSS resources in counties
- Funding additional HCPF resources to improve communications to counties and provide additional on-site support for counties

Questions 50-57: Escalations

Escalations Process supports members
Members can escalate any issue related to financial or functional eligibility, including case issues, long term care, customer service and general complaints

Request reflects a stabilized volume of escalations

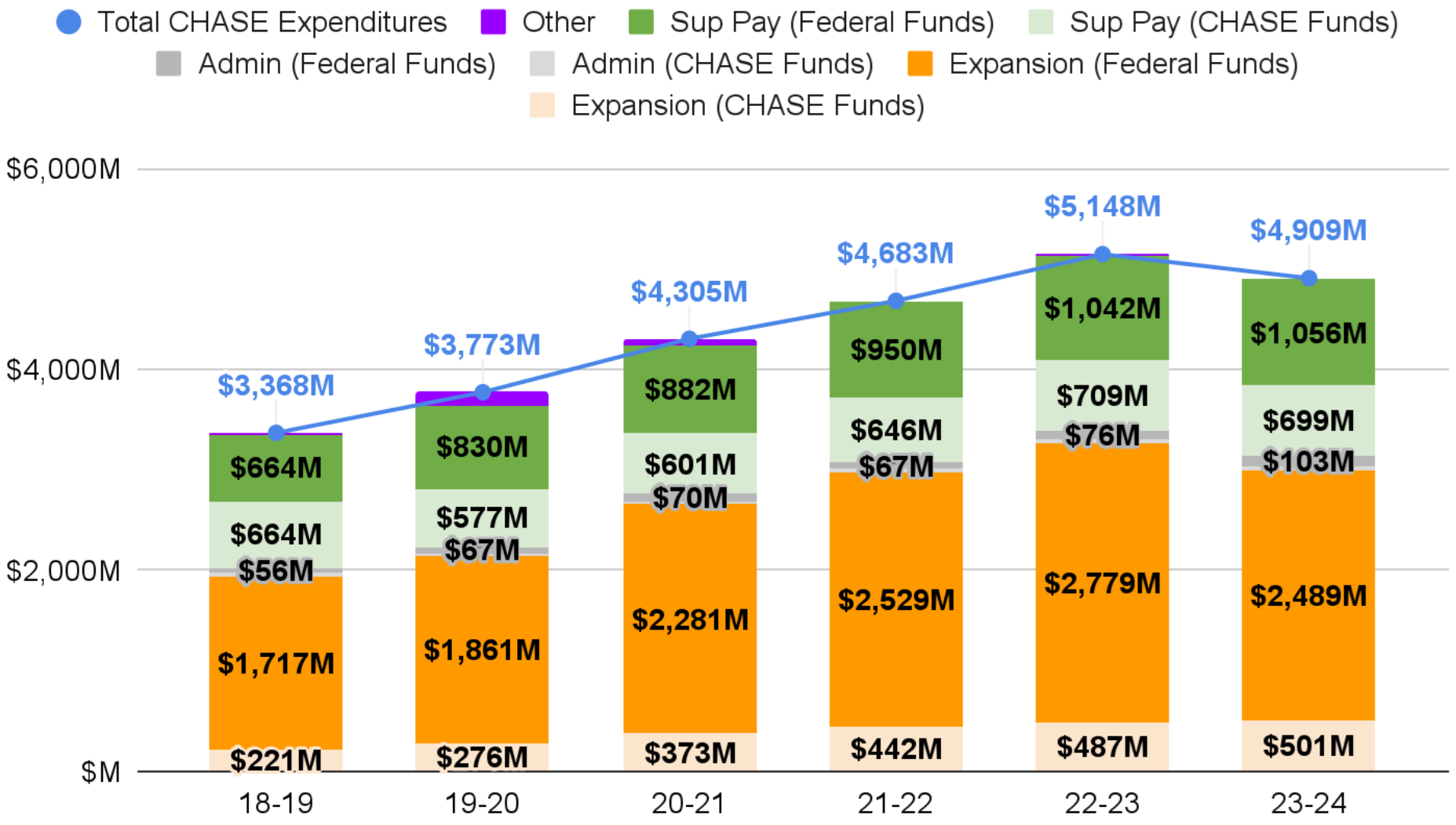
Root cause analysis to address issues raised in escalations



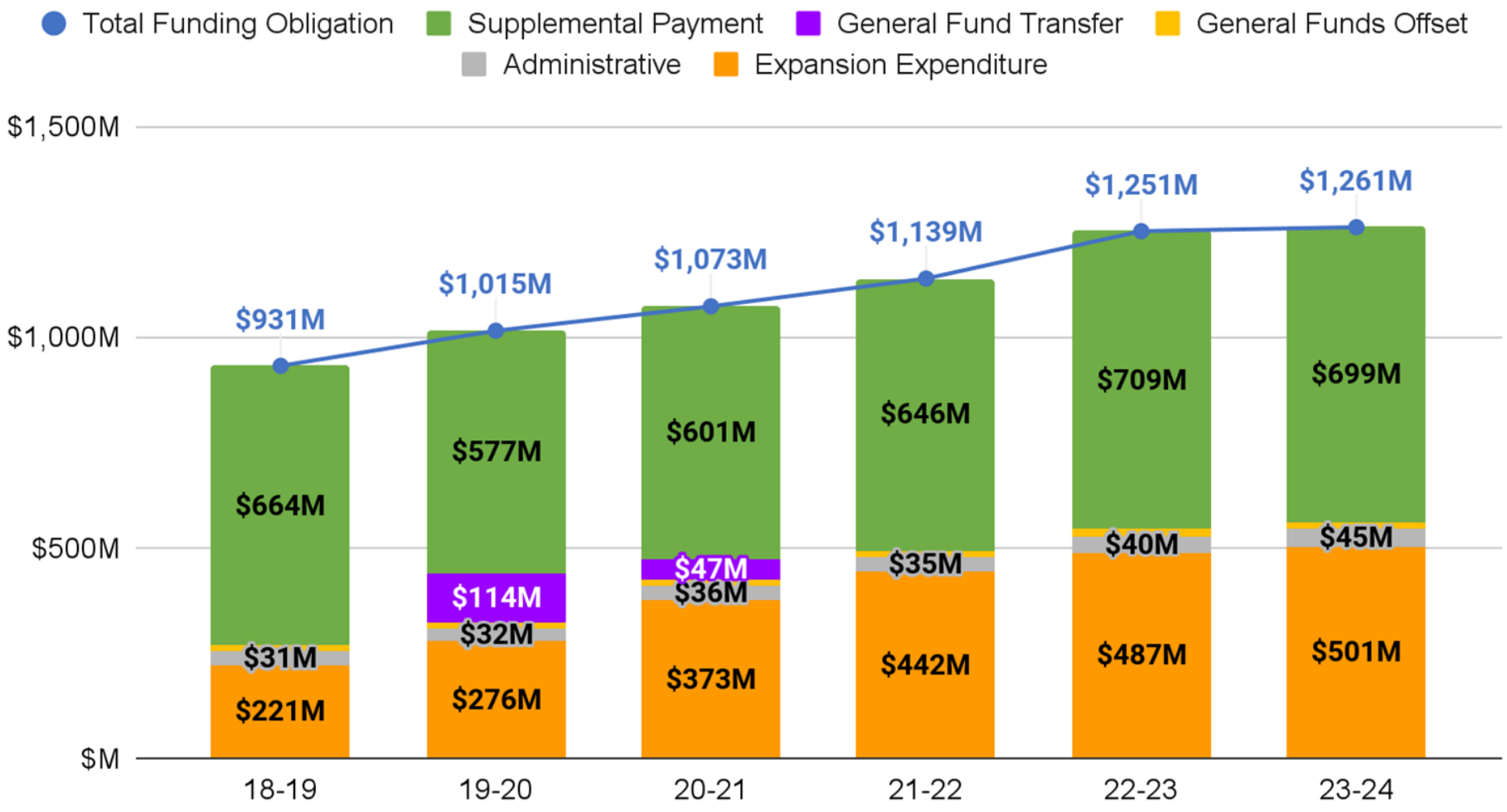
Questions 58-61: Colorado Benefits Management System

Provider Fees: Questions 62-70

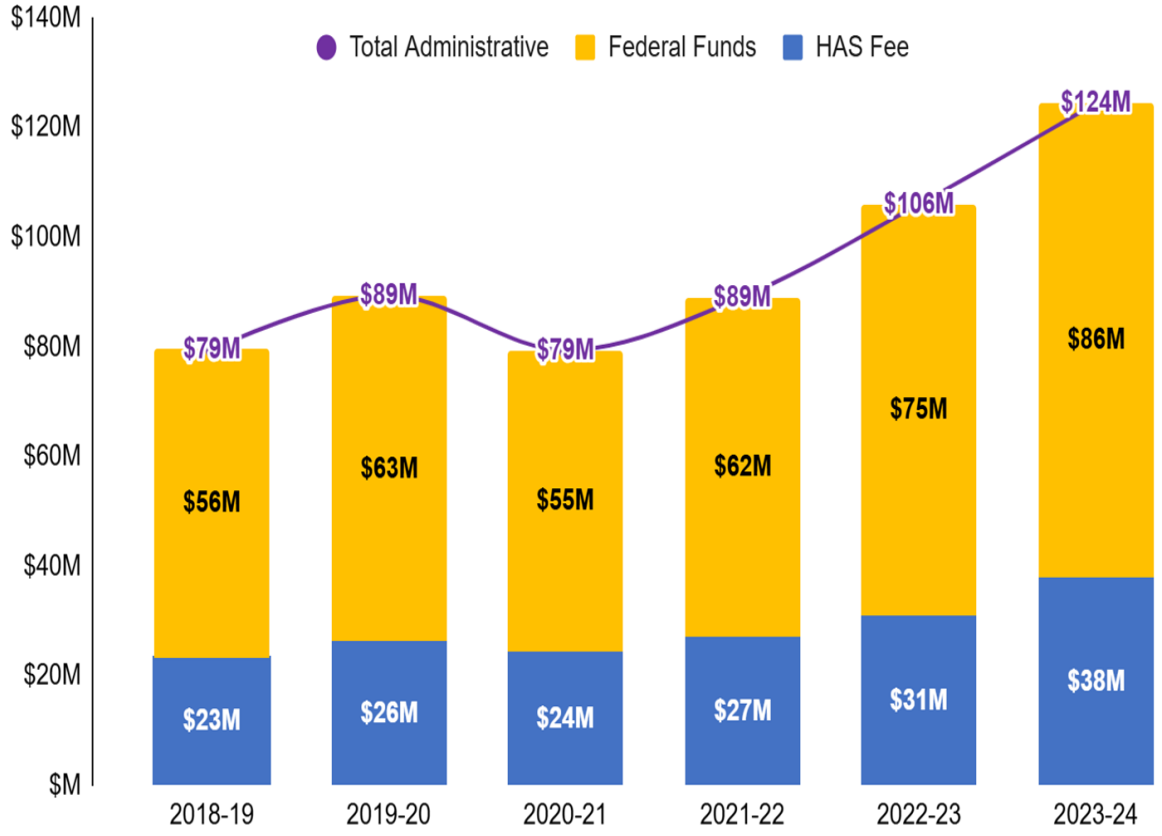
Question 62-63: Provider Fees

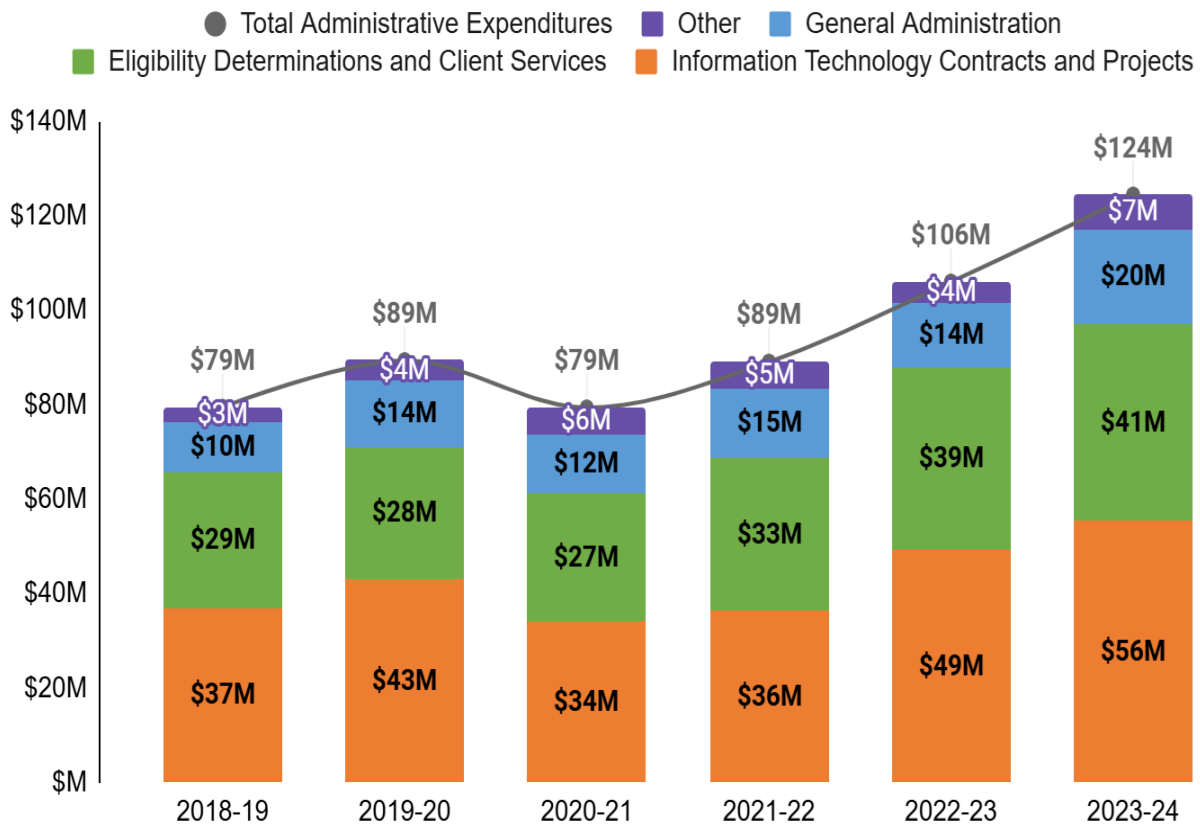


Total CHASE Fee



Question 64-65: Provider Fees

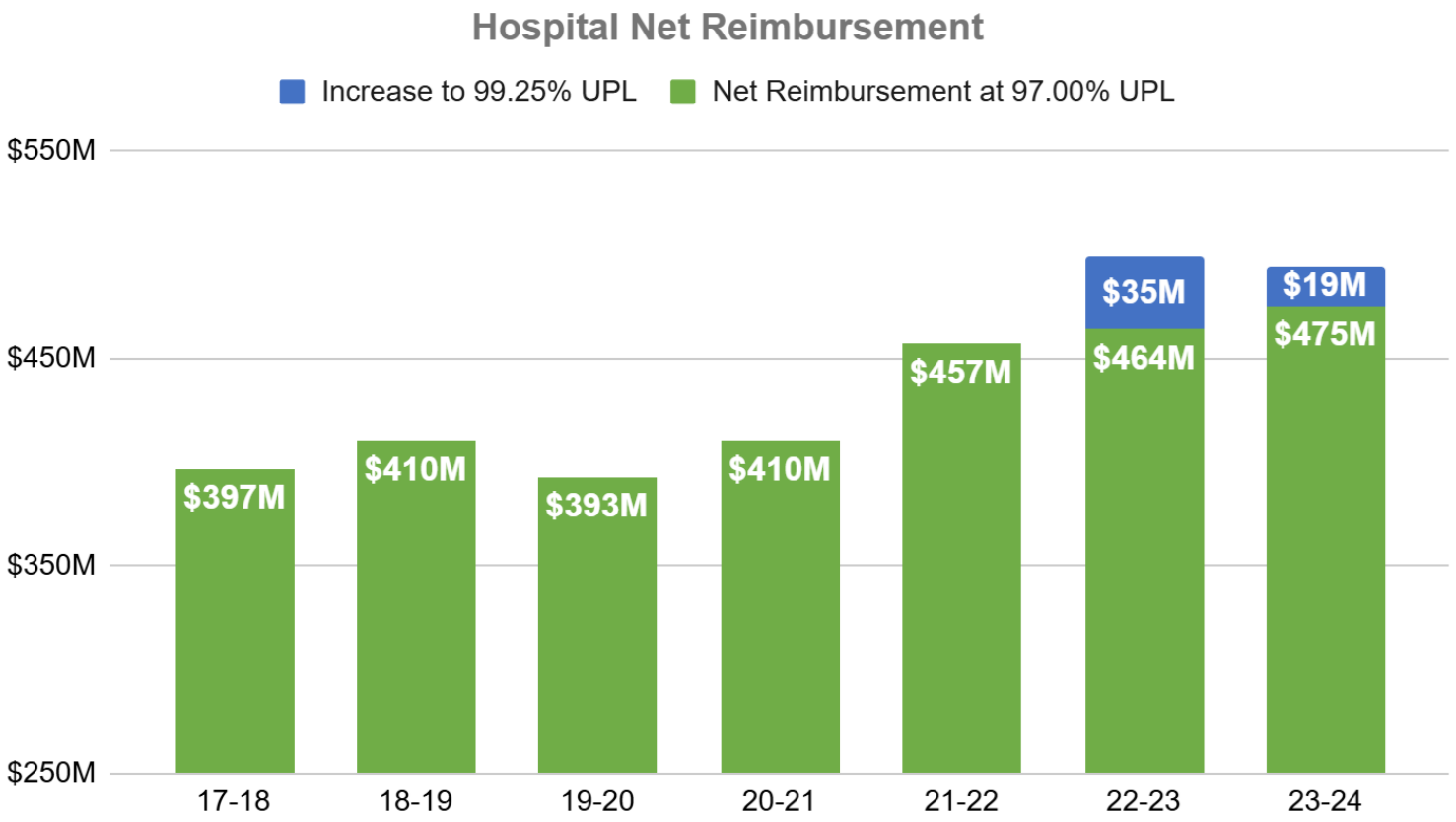




Question 66-68: Provider Fees

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%**

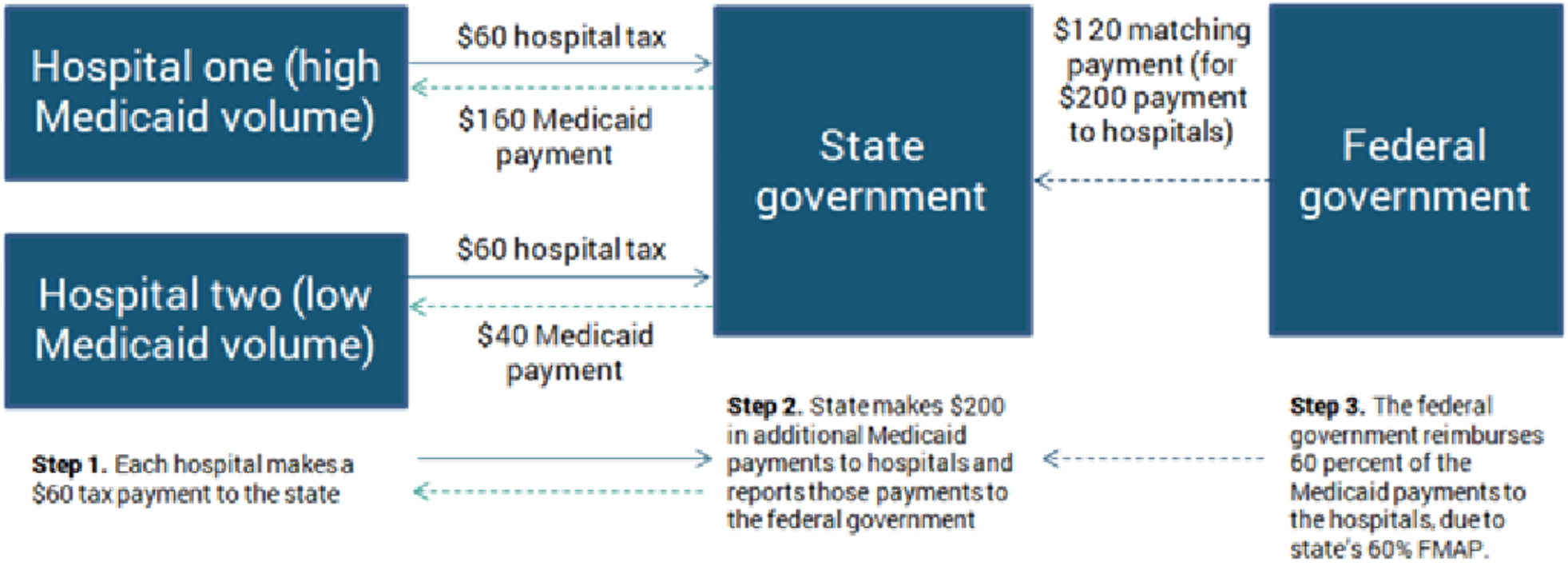
Question 69: Provider Fees



- CHASE model to 99.25% of UPL created $54M in add'l funds released Dec. 16 to hospitals.
- Precedent set in FY2010-11 ~$150M and in FY2020-21 with HB20-1386 authorized $161m of CHASE cash fund as Medical Services Premiums GF offset.

Question 70: Provider Fees

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.

Source: May 2021 Issue Brief from the Medicaid and CHIP Payment and Access Commission (MACPAC)

Safety Net and Denver Health: Questions 71-72

Question 71: Rural Safety Net Providers

- **Improving Rural Access and Affordability** - $5.5M rural hospital access, $10.6M rural access and affordability
- **Hospital Transformation Program Rural Support Fund** - $60M over 5 years to help 23 critical access and rural hospitals modernize
- **Rural Connectivity and Access to Virtual Care** - $17.4M in federal matching funds over 4 years; **100%** of rural safety net providers now connected to state health information exchange to support rural member access to care and keep care local; incentive payments for rural providers
- **SB23-298 enables rural hospitals to collaborate/cooperate** without violating anti-competitive federal or state laws
- **Colorado "Internet for All"** - $826M state grant program to achieve 99% connectivity goal; initial proposal approved
- **ACC Phase III - ACO-like support** for rural RHCs and Independent PCPs

Question 72: Support for Denver Health

- HCPF continues active engagement with Denver Health to explore ways to assist and stabilize Denver Health as a vital safety net hospital in the state
- HCPF's efforts includes reviewing existing supplemental payment methodologies already in place to ensure we are drawing all federal funds available and exploring potential new opportunities
  - Existing payments include those for ambulance and physician services and its 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 with the City of Denver, including exploring opportunities to draw additional federal matching funds on funds made available to Denver Health through the recent passage of Ballot Measure Q2

HB 22-1289 Cover All Coloradans: Questions 73-80

HB 22-1289: Cover All Coloradans Overview

Coverage Expansions

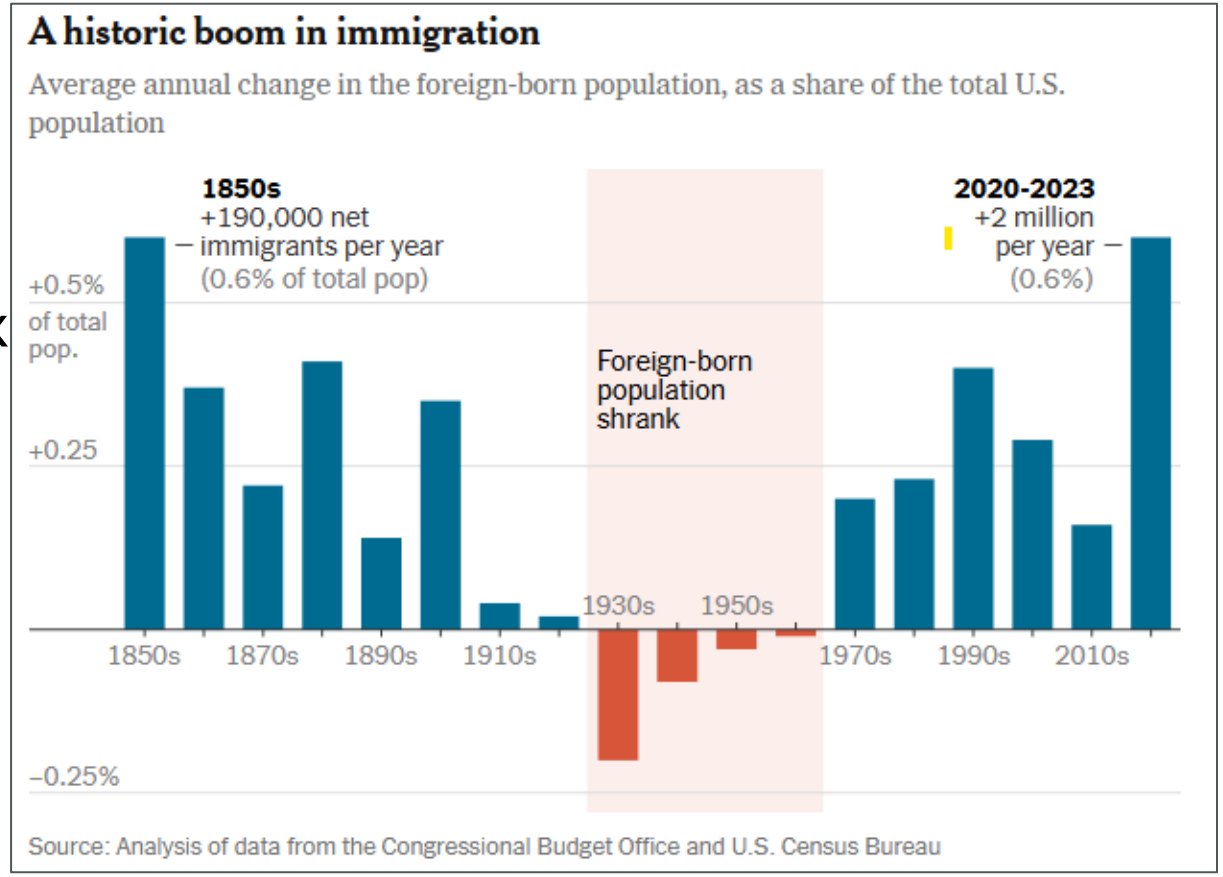
- Coverage starts January 1, 2025
- Colorado children ages 18 and younger and pregnant people regardless of immigration status
- Health First Colorado and Child Health Plan *Plus* (CHP+) look-alike programs
- Must meet income and household eligibility for Health First Colorado and CHP+
- Children state-only funded; pregnant and postpartum receive CHIP match

Additional policy changes

- Eliminate CHP+ enrollment fees
- 12-months postpartum coverage
- Expanded lactation benefits
- Health Services Initiative programs

Immigration Surge

- Largest growth in immigration since the late 1800s
  - Foreign-born pop. reached record high: 15.2% in summer 2023
- Impacts of PHE unwind and migrant influx on uninsured rate difficult to differentiate
- Cover All Coloradans
  - Enrollment numbers ~9,100
- OmniSalud
  - 12,000 spots for 2025; 8,500 individuals re-enrolled; 3,500 newly covered



David Leonhardt, "The Largest Immigration Surge in U.S. History," *The New York Times*, December 11, 2024, https://www.nytimes.com/2024/12/11/briefing/the-largest-immigration-surge-in-us-history.html

Question 73-75: HB 22-1289 Projections

Fiscal Note assumptions

New Estimates

- Surge in newcomers in 2023 and experience of CO providers, particularly Denver Health
- Experiences of other states
- Experience in OmniSalud

Old Estimates

- Based on data available at the time and low uptake in family planning program for immigrants

PMPM assumptions

- Dept actuary projects and experience with DHMP FFS + Oregon state experience of kids as low utilizers

Election Impact

- Expected chilling effect on new enrollments and utilization from enforcement actions and anticipated changes to public charge

Question 76-77: Outreach, Education, Training

Community Ambassador Program

- 17 community organizations across the state
- Education and outreach from local trusted resources
- Monthly webinars x2
- Tool kit: FAQs updated regularly, newsletter content, social media content, fact sheet, fliers, translated into Spanish, Dari, Chinese, Amharic, Russian, Vietnamese, Arabic

County Training

- CBMS build training released in October (33 counties)
- CAC specific training (42 counties)
- Agenda item at county eligibility and leadership meetings thru 2024
- Policy and operational memos
- One-page fact sheet for county audience

Question 78-80: Impact, Uncompensated Care

Current State:

- Coverage for currently uninsured patients presenting at clinics and emergency rooms for care
  - Emergency Medicaid (EMS)
  - Uncompensated Care at Hospitals
  - “Regardless of ability to pay” Federally Qualified Health Centers
- Medicaid Match ~50/50
- Provider Loss

Proposed State:

- Invest in Preventive care to reduce high cost service utilization (prenatal care lowers C-sections & NICU stays)
- Reduce provider burden by limiting public health program dependence and uncompensated care rates
- Maximize federal match with more reimbursable services at higher match rate (65/35)

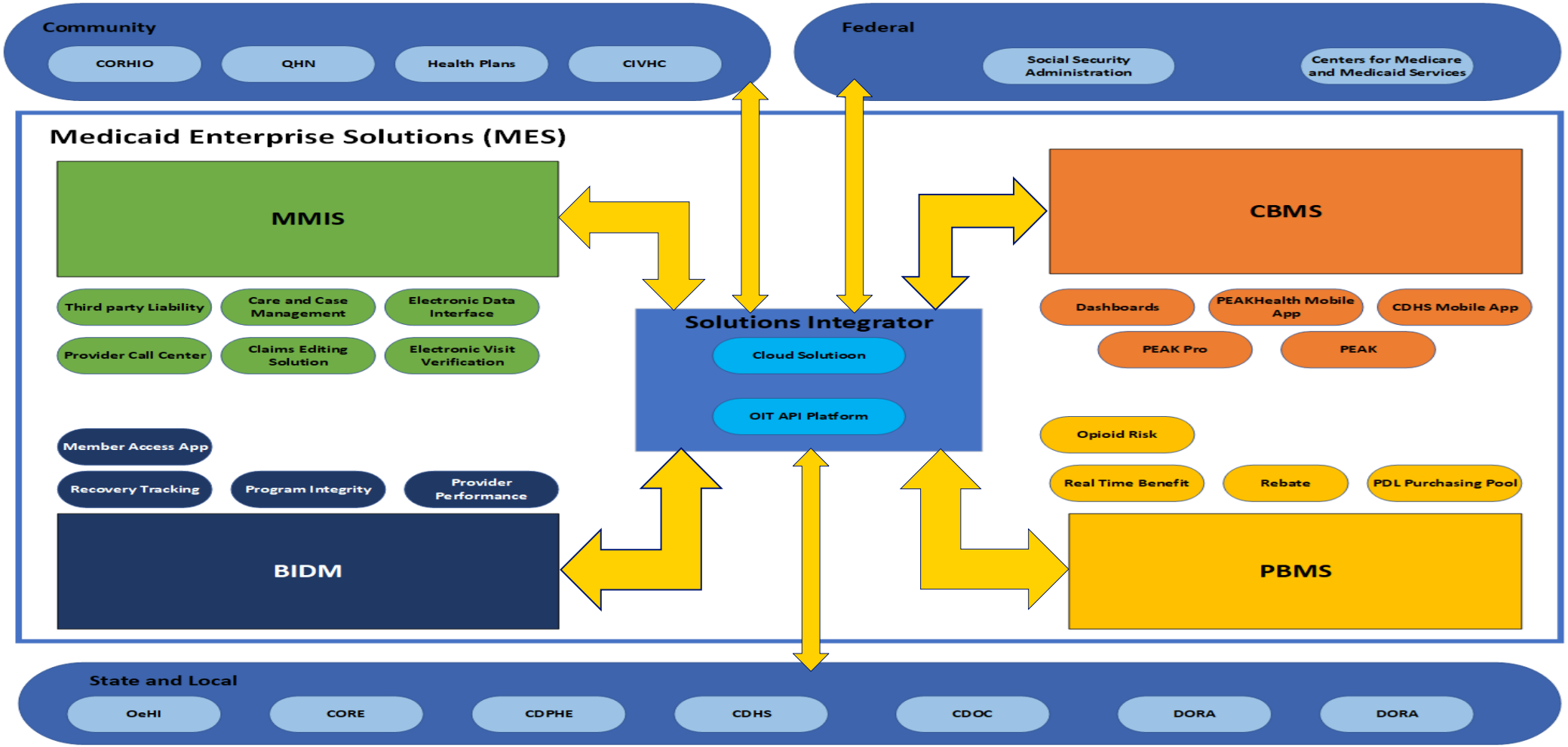
All Payer Claims Database: Questions 81-82

R8 Colorado Medicaid Enterprise Systems (CMES): Questions 83-84

Question 83: R8 Request

- JBC referred R8 to the JTC for approval
- Department requests
  - $350,197 General fund
  - $1,938,089 Total Funds
  - 18 FTE
- Manage the increased administrative costs resulting from the Colorado Medicaid Enterprise Systems (CMES) modular Procurement Project

Question 84: CMES Environment



Transition Summary: What Is and Is Not Changing

No Change in Any Way	Recontracted directly. Same vendor. No Middleman	New Data Warehouse. Same HCPF Analytics, People and Reporting	Replacing Current Vendor
• 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 won two modules) • PBMS, Rebates and Preferred Drug List, Prescriber Tool - Real Time Benefit Tool

Resources in Request

Goal is to drive smooth transitions, no business interruption. Resource allocation is critical to achieving that goal.

- 90/10 funded thought enhanced match
- 3 Business Analyst FTE at the Analyst IV level
- 4 Testing FTE at the Analyst IV level
- 5 Project Management FTE at the PM1 level
- 3 Contract Management FTE at the Contract Administrator IV level
- 3 Operational Support FTE to support

Common Question for Discussion C-01

Thank You