Joint Budget Committee Hearing
Health Care Policy & Financing

Dec. 19, 2023

Kim Bimestefer, Executive Director
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Adela Flores-Brennan, Medicaid Director
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Thank you for your partnership

- 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

Average 1.6M covered lives over FY

- Covering **1 in 4** Coloradans
- **40%+** of Colorado's children
- **40%+** of births
- **4%** of members use long-term services & supports (LTSS)

Change in Medicaid population

ACA Expansion (2014-2016)

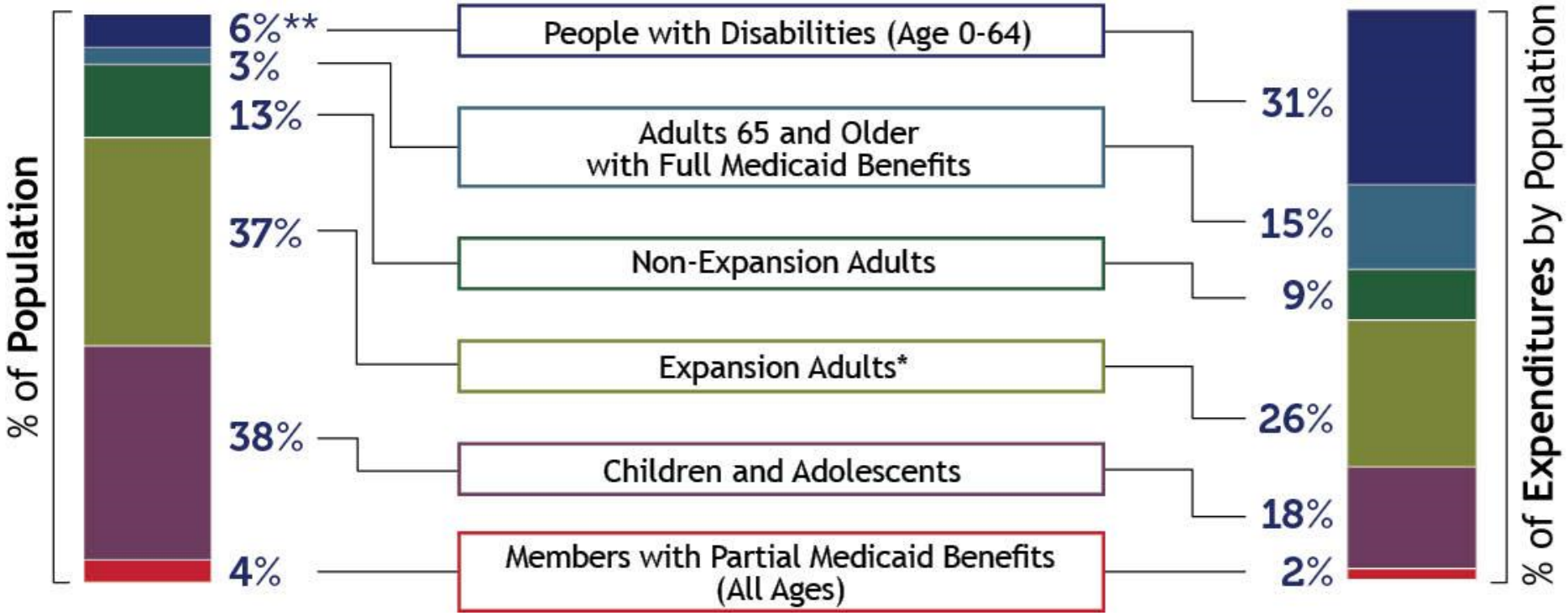
Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2012-13	682,994	5,194,662	13%
2015-16	1,296,986	5,446,593	24%

COVID-19 Pandemic (March 2020-April 2023)

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2018-19	1,261,365	5,676,913	22%
2022-23	1,719,393	5,838,736	29%

- Significant surges in Medicaid enrollment. Now PHE disenrollments.
- Changing demographics impact costs, trends, needs
- Fed funding impacts revenue: 90/10% expansion; 6.2% added FMAP thru PHE
- Returned $1.7B to JBC of add'l 6.2% FMAP through June 2023
- Enhanced federal match fully expires fiscal year 2023-24, accounting for $89M of the General Fund requested in FY 2024-25

HCPF $$ by major enrollment category



*ACA Medicaid Expansion 90/10 federal funding for Expansion Adults, state fund source: the Healthcare Affordability and Sustainability Fee (CHASE)

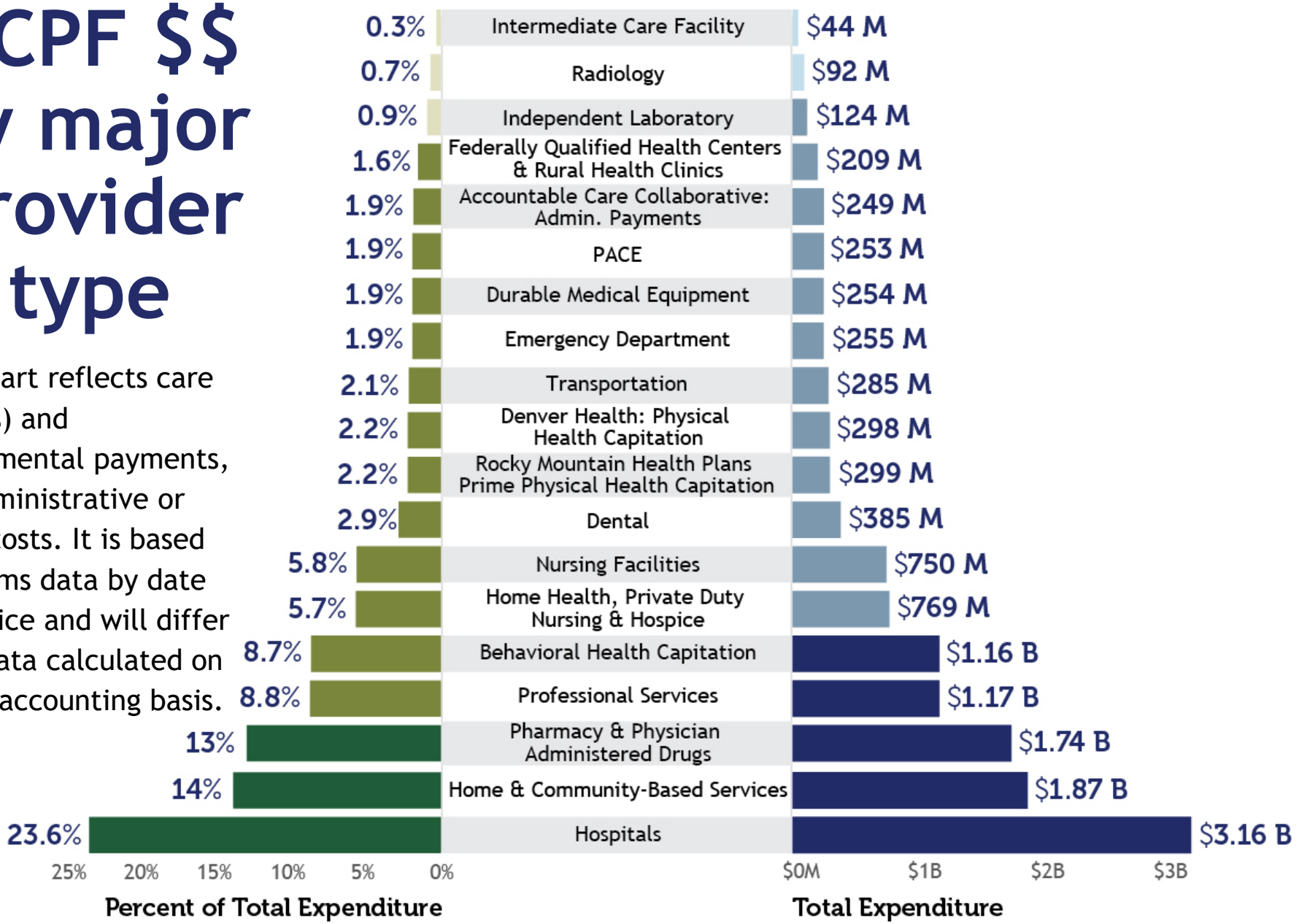
**Not all members with disabilities use long-term services & supports (LTSS)

Responding to dynamic environment

- **Expanded access to care, with enrollment surges:** number of providers enrolled March 2020 to Nov. 2023 up >50%
  - Continued challenges in access: behavioral health, home and community based services, front line workers (CNAs, RNs) for hospitals, nursing homes, PBT/ABA, and the like
- **Massive system changes necessary to navigate the PHE and other priorities:** 242 claim system projects since Sept. 2019
- **High member and provider call center standards:** calls answered in <60 seconds, medical claims paid in <5 days
- **Controlling claim trend and admin**
  - 2.1% claim trend per person per month (FY 2022-23)

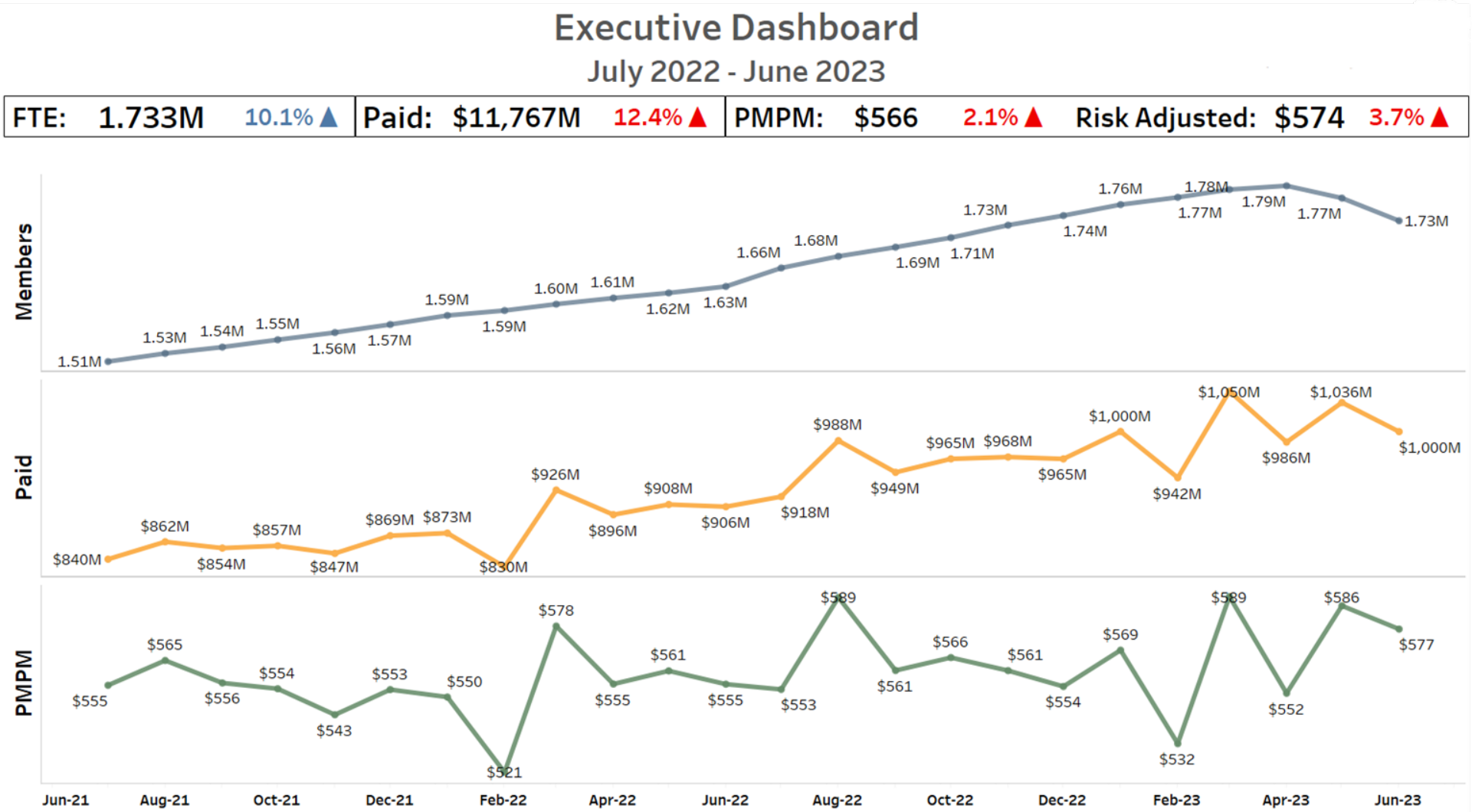
HCPF $$ by major provider type

This chart reflects care (claims) and supplemental payments, not administrative or other costs. It is based on claims data by date of service and will differ from data calculated on a cash accounting basis.



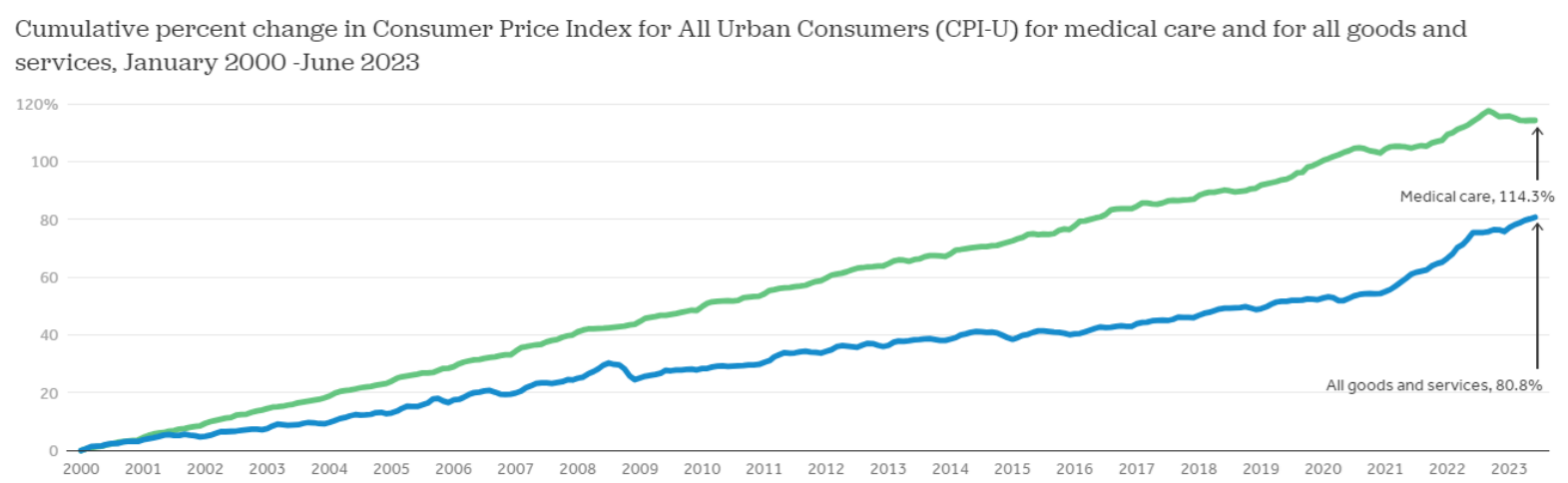
Source: FY 2022-23 data via HCPF Annual Report

Fiscal year 2022-23 trend



Challenges in managing Medicaid trend

- **Balancing access and provider needs:** across-the-board (ATB) rate increases 1% (FY 2024-25 request), **3%, 2% and 2.5% last 3 years,** plus pending targeted provider reimbursement rate increases
- **Medical costs increase faster:** Consumer Price Index (CPI) 80.8%, Medical CPI 114.3% (KFF, CYs 2000-2023)
- **Aging Population:** Colorado 2nd fastest growing state for 65+; 70% of people over 65 will need long term care at some point, 20% for >5 yrs
- **Specialty drugs — U.S. biggest driver of healthcare costs**
  - $1.6B in Medicaid pharmacy costs last FY (gross of rebates); >8.8M Medicaid pharmacy claims paid; <2% of drugs so expensive, driving 49%



Recent actions to address provider hardship

- **Nursing Home:** $131M investment over 2 years (HB 1228)
- **HCBS:** $12.41 to $15 (1/1/22) to $15.75/hr (7/1/23) to $16.55/hr thru this recommendation (Denver $17.29/hr to $18.29/hr eff 7/1/24)
- **Rural Hospitals:**
  - **Rural Access and Affordability Grants** - $10.6M
  - **Rural Support Fund** - $60M over 5 yrs ($12M/yr) for 23 hospitals
  - **CHASE Prepayments** to help cover payroll for 2 hospitals
  - **Rural Connectivity and Virtual Care** - $17.4M over 4 years; **100%** of rural safety net providers now connected to state HIE, plus funding to maintain connection
- **Denver Health safety net:** $5M to help with IT advances, i.e., HIE connectivity, eConsults and eligibility processing support
- **Parkview joins UCHealth -** $26M CHASE funding continued
- **General workforce recruitment and support**

Value Based Payments (VBPs)

Target: 50%+ in VBP by 2025 (currently 30%)

Part	Program	Participation
Hospital	Hospital Transformation Program	100% of hospitals
Primary Care	→ capitation, 16% rate increase	~530k/37% members
Prescription Drugs	Value-based arrangements Prescriber Tools	4 (+50%) ~11k/50% prescribers (+15%)
Maternity Care	Bundled payments care episodes	~30% deliveries (+7%) Denver Health joined 11/1/23

Also:

- **Behavioral Health**: ensure safety net accountability - in development
- **Nursing Homes**: pay-for-performance program to increase quality

Quality, health equity and innovation to manage cost trends

- **Utilization management**: right care, right place, right time, right outcome, right price
- **Population health**: maternity, diabetes
- **Complex case management**: high need, high cost members
- **ACC Phase III:** Medicaid system evolution
- **Innovations**: Prescriber Tools, eConsults, cost and quality indicators to drive better provider decisions, quality, efficiency, equity
- **Fraud, waste, abuse, global attacks**: software, Recovery Audit Contractor (RAC)
- **Value based payment advances**

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.

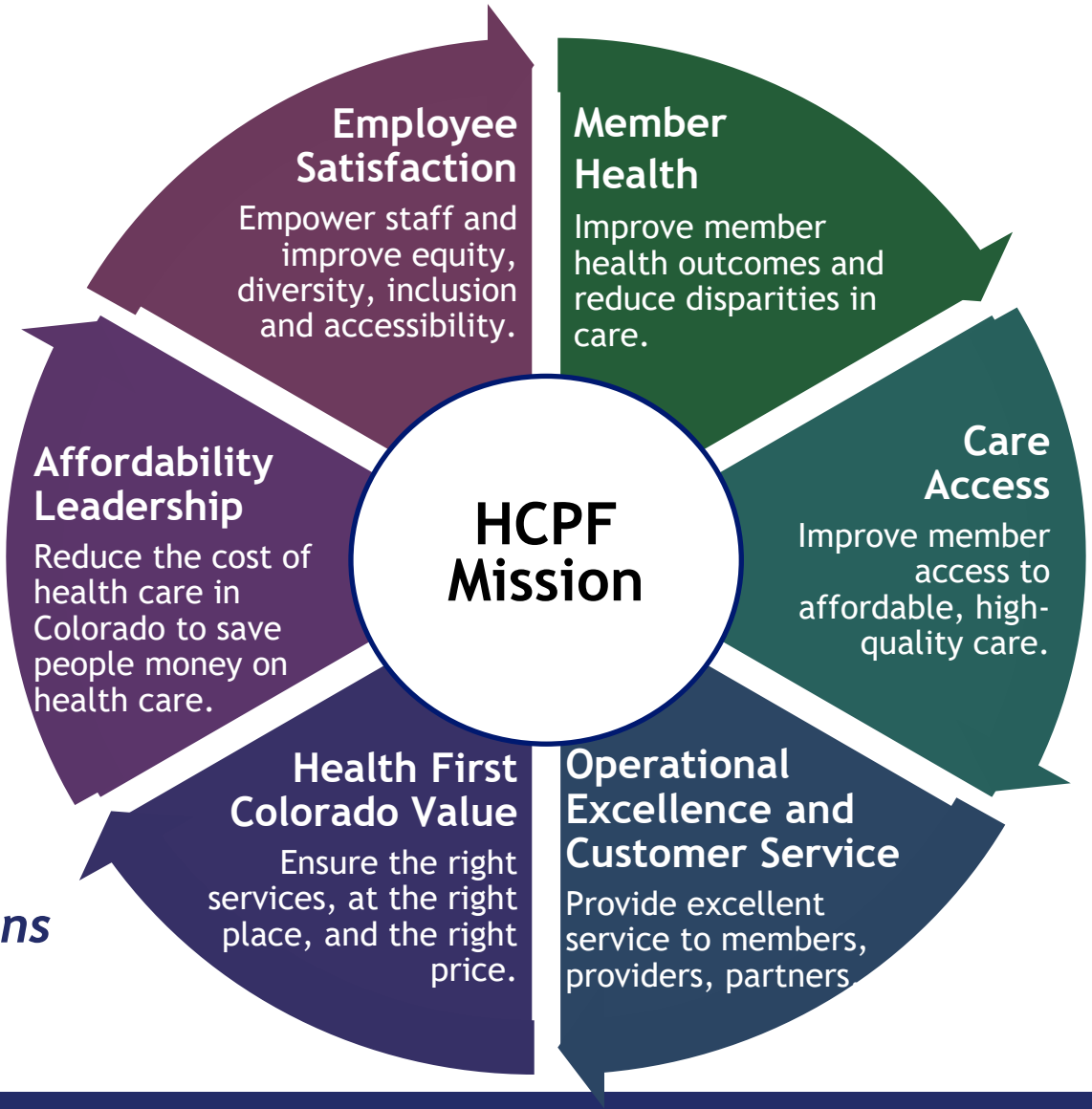
Dynamic Change — Big Boulder Focus

- **Balancing:** inflation, provider rates, workforce and access gaps; mitigate struggling provider risks
- **Keep Coloradans Covered:** post PHE continuity of coverage
- **Transform behavioral health**
- **Transform long term care for people with disabilities and older adults:** HCBS thru American Rescue Plan Act; nursing homes; case management redesign
- **Promote health equity:** behavioral health, maternity, prevention
- **Advance value based payments** to reward quality, equity, access, affordability
- **Drive innovations:** eConsults, Prescriber Tools, social determinants of health, cost and quality indicators
- **Modernize how Medicaid delivers care:** Accountable Care Collaborative Phase III
- **Modernize Medicaid Systems**
- **Saving people money on health care**

Dynamic Change — HCPF Response

- Agility: fewer vendors, more FTE; maintaining 4% admin (0.44% staff) (carriers 13.5%+ admin)
- 10 offices to hold ourselves and vendor partners accountable
- Advance infrastructure
- Productivity: 45 goals supported by 95 projects

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



HCPF FY 2024-25 Budget

- **$16.4B Total Funds, $5.0B General Funds**
  - **31%** of state's GF operating budget
  - **96%** continues to go to providers, 4% admin, 0.44% HCPF staff
- Increase of $934M TF, $402M GF, most from:
  - $320M GF — normal year-over-year growth in Medicaid
  - $76M GF and $249.2M TF — provider rate increases as subset of $82M GF discretionary requests
- Discretionary budget requests ($282M TF and $82M GF):
  - R6 | Increase Provider Rates
  - R7 | Behavioral Health Continuum
  - R8 | Eligibility Compliance
  - R9 | Access to Benefits
  - R10 | Third Party Assessments for Nursing Services
  - R11 | Program Support
  - R12 | Administrative Resources
  - R13 | Convert Contractor Funding to State FTE
  - R14 | Increase the Budgets of Two Critical Contracts
  - R15 | Continuing Support for Denver Health and Hospital Authority

Discretionary budget requests respond to provider and member needs

Provider Rate Increases

- 1% across-the-board rate increase
- Targeted adjustments for Pediatric Behavioral Therapies, ambulatory surgical centers, surgical, behavioral health, maternal health, dental services and anesthesiology
- Increase direct care workforce base wages
- Support eligibility processing, IT/innovation advances of largest safety net provider, Denver Health

Better Care and Access

- Support individuals with disabilities and older adults on waivers and other long term care programs
- Make significant investments to continue transforming the behavioral health system
- Advance provider tools to improve whole-person health
- Modernize eligibility, claims systems
- Resources to improve quality and ensure compliance

Children and Youth

- Support families of youth with high-acuity behavioral health needs
- Cover Autism Spectrum Disorder treatment for CHP+
- Accounts for Health First Colorado coverage of pregnant adults and children who are DACA recipients, pending federal requirements

Common Questions for Discussion 1-3

Behavioral Health

Kim Bimestefer, Executive Director
Cristen Bates, Behavioral Health Initiatives and Coverage Office Director

Behavioral Health

- Medicaid behavioral health investments from $630M to $1.2B/year in last 5 years
- Close collaboration with the Behavioral Health Administration (BHA)
- Behavioral Health Administrative Service Organizations (BHASO) and Regional Accountable Entities (RAEs) alignment in policy and practice
- New provider types, service provisions, associated funding
- Integrating primary care, mental health, substance use
- Improving the crisis continuum with focus on community delivered services, reducing the reliance on law enforcement and ERs
- Prioritizing gaps in care: children and youth, persons with disabilities, co-occurring intellectual or developmental disabilities, people who are unhoused, and people who have been incarcerated
- Increasing high-intensity outpatient and transition services
- Adding adult beds, youth residential beds, tribal substance use disorder facility

Behavioral Health Questions 1-2

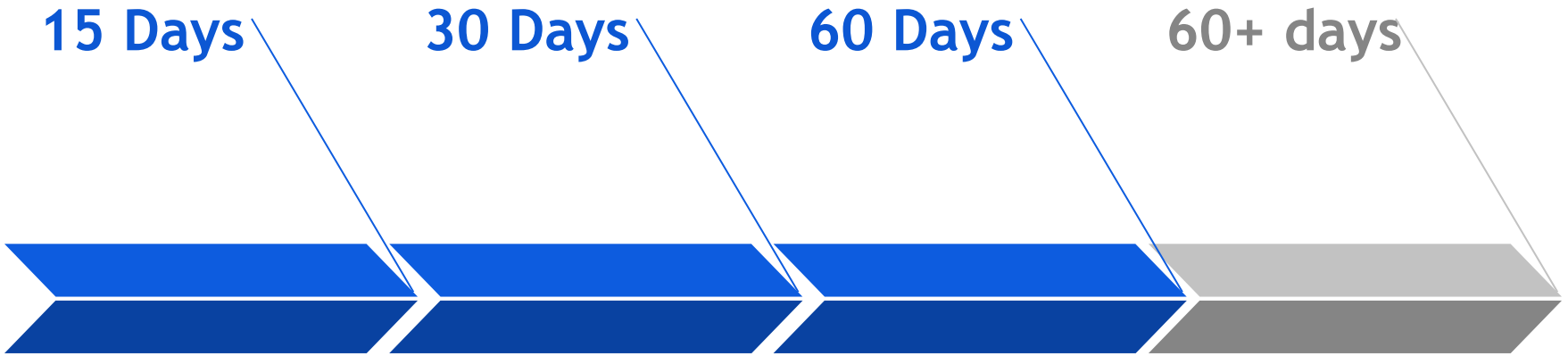
Inpatient Mental Health Services

Who needs the expansion beyond 15 days:

- 3.2% of stays in an IMD had a **single length of stay** between 16-30 days, which currently may not be reimbursed because they exceed 15 days in a calendar month.
- While 96% of stays in an IMD are less than 15 days, a member with **multiple episodes of care** in an IMD in the same calendar month, which combined exceed 15 days, occurs on average 15 times per month.

Looking at both multiple and single stays, this impacts 24 visits (or 15 members) per month.

Associated Costs for IMD Expansion Beyond 15 days



Currently cover only if LOS ends here. Cost to cover for 15 days regardless of LOS: $2,450,304 Total, $582,769 GF.

Covering an average LOS of 30 days: $7.2 million Total, $1.8 million GF. All other approved states use this standard.

A "30 Day" waiver as approved in other states also covers inpatient up to 60 days.

60+ Days would be required, but not receive a federal match. Very rare, but needs GF only funding, <$20K.

Regional Accountable Entities (RAEs) / Accountable Care Collaborative (ACC) Phase III Questions 3-4

RAE Accountability

Contract Management

- All RAE contracts approved by CMS
- Contracts include stringent statements of work
- Regular contract amendments in response to environmental changes, state priorities, etc.
- Corrective actions

Quality

- RAE and provider performance measured on:
  - Quality metrics
  - Stakeholder feedback
  - Customer service standards
  - Independent audits
- Incentive payment program

Performance Monitoring

- HCPF reviews RAE deliverables to assess operations, finances, program strategy, etc.
- Action monitoring plans or corrective action plans
- Grievances and appeals process
- Independent Managed Care Ombudsman

RAE Provider Engagement

Strategies:

- Managed care provider complaint form
- Program Improvement Advisory Committees (PIAC)
- Stakeholder meetings
- Targeted Independent Provider Network (IPN) engagement
- Technical assistance
- Executive Director site visits

Provider feedback results:

- Contract amendments.
  Ex: 90 days to contract and credential new providers
- Public reporting.
  Ex: HCPF 2023 report BH Rates, RAE performance dashboard
- Streamlined and standardized policies.
  Ex: pre-licensure, ASAM education, credentialing

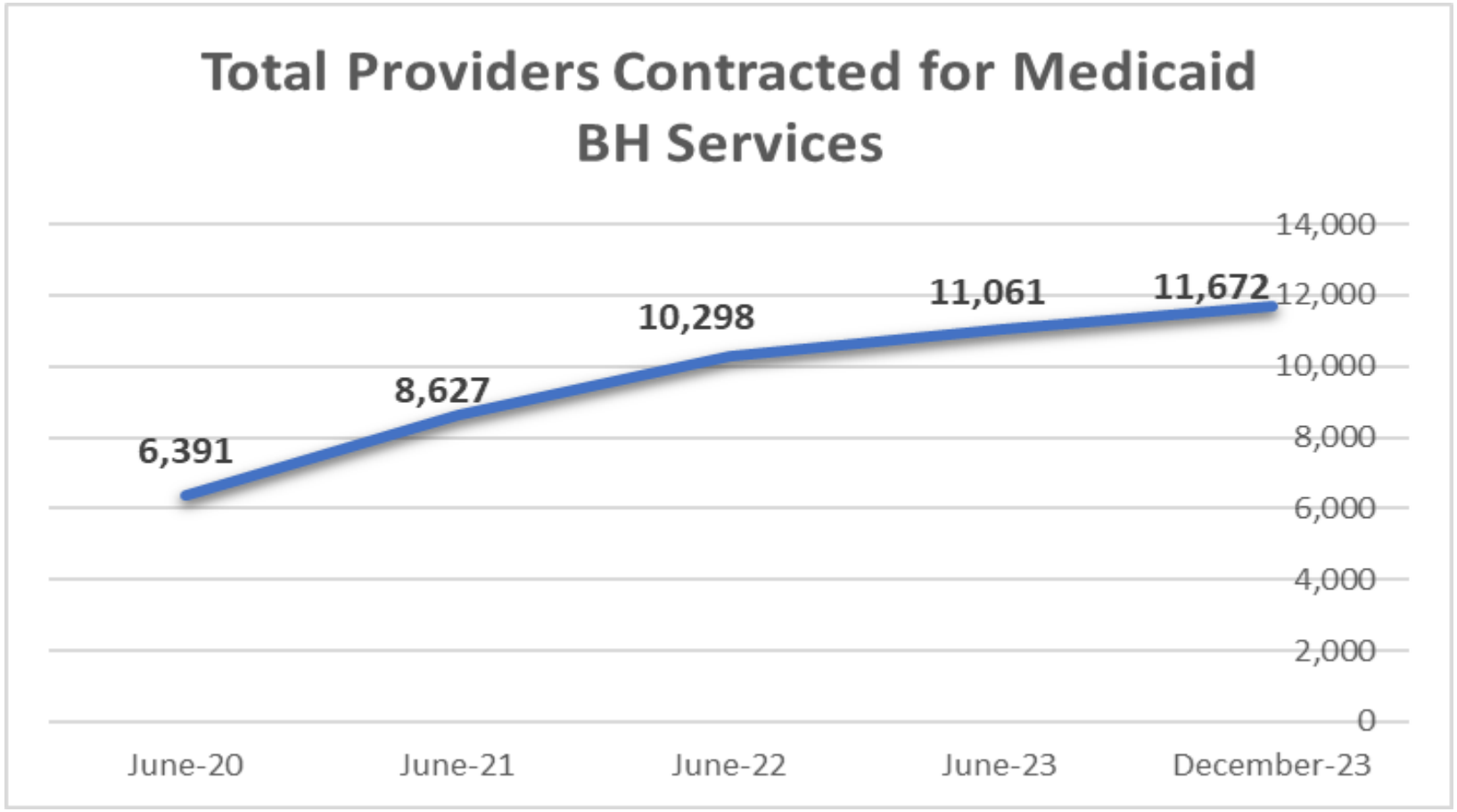
RAE Standardization

- Identical contracts
- RAE deliverables
- Independent audits
- Quality metrics
- Directed payments
- Universal contracting provisions

Why be a Medicaid Provider?

- No co-pay, no deductibles, no authorization for most outpatient services - most comprehensive coverage package of services in the state
- New safety net provider rules, provider types
  - Essential Safety Net Providers
  - Comprehensive Safety Net Providers
- HCPF works closely with providers and RAEs to continue expanding the provider network, strategies include:
  - Educational campaigns with DORA to reach BH providers not contracted with Medicaid
  - BH safety net transformation
  - Increased reimbursements rates in FY 2022-23
  - Centralizing credentialing and streamlining contracting
- Between 2021 and 2022, provider satisfaction scores increased for both RAEs and HCPF

Providers may be a single therapist or a large facility, and cover almost every service in the BH continuum of care



Building BH Networks

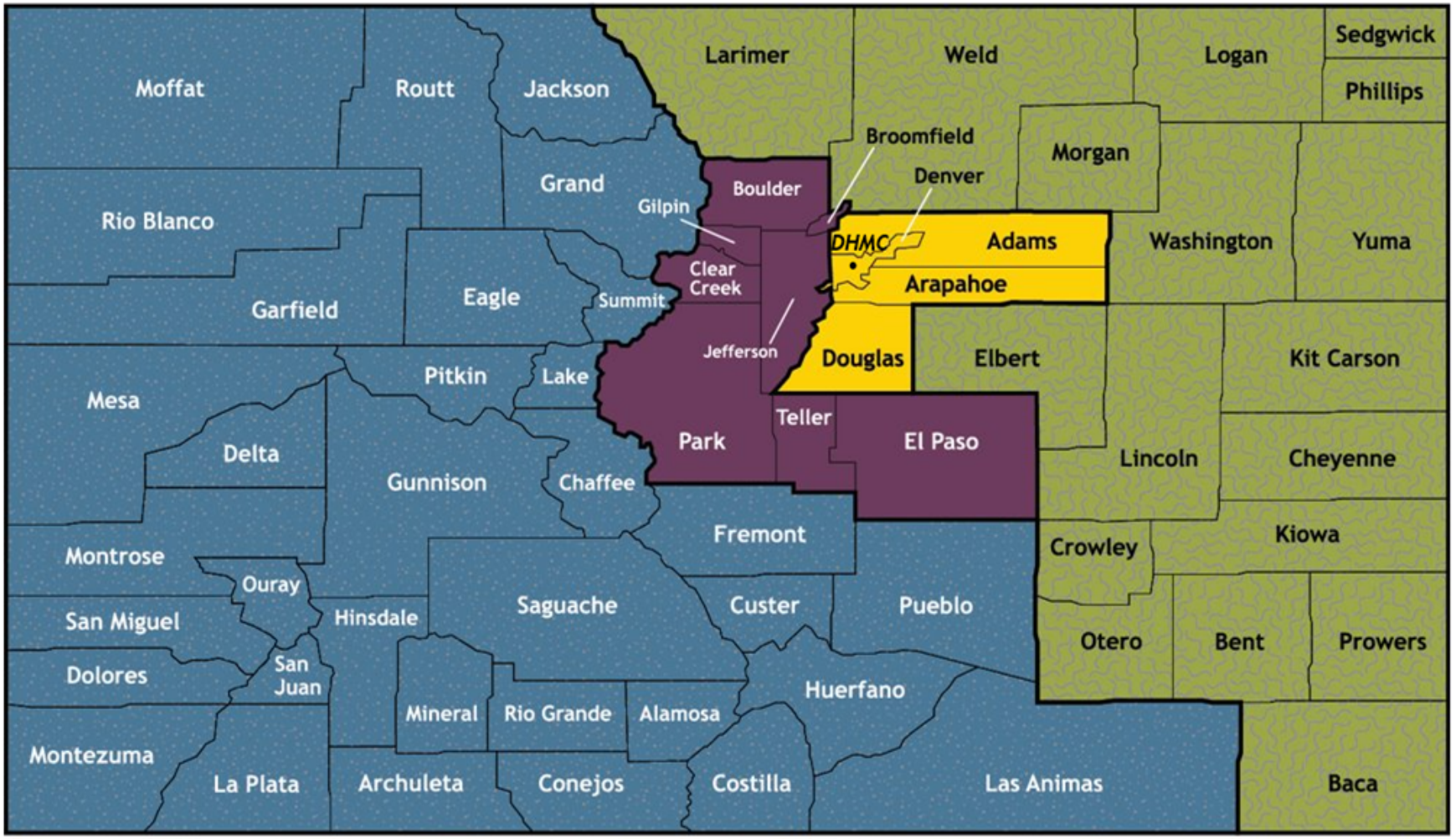
Total Number of RAE Contracted Behavioral Health Providers by Fiscal Year

	FY 21-22	FY 22-23	FY 23-24
RAE 1	3,293	3,361	6,248
RAE 2	3,100	3,298	4,175
RAE 3	6,118	5,662	8,405
RAE 4	3,097	3,297	4,176
*RAE 5	6,211	6,742	8,408
RAE 6	3,921	5,999	8,103
RAE 7	3,921	5,999	8,103

*Includes Denver Health Behavioral Health

- **Since FY 2021-22, all RAEs have expanded their BH provider networks**
- **HCPF has also targeted key services for members:**
  - High-Intensity Outpatient
  - Peer Support
  - Residential Substance Use Disorder Service Providers
- **New Safety Net Providers**
  - 6 provider organizations intend to be comprehensive
  - 72 interested in essential
  - 44 new licenced agencies with 53 sites
  - 52 new locations for existing licensed providers
- **We still have a lot of work to do!**

Final ACC Phase III RAE Map



Public Health Emergency, County Administration & Appeals Questions 5-22

Partnering to Keep CO Covered

PHE Unwind Goals

1. Member continuity of coverage
2. Smooth transitions in coverage
3. Minimize impact to eligibility workers and staff

Initial Focus:

- Maximizing auto-renewals (~30%)
- PEAK investment
- Robust communication resources
- Stakeholder education and engagement
- Provider partnership
- Member update your address campaign: 34% increase in emails and text sign ups
- Support for counties
- RAE engagement
- Auto enrolling children into CHP+ if they disenroll from Medicaid, when eligible

Question 5:
Change in Medicaid population

ACA Expansion
(2014-2016)

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2012-13	682,994	5,194,662	13%
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COVID-19 Pandemic
(March 2020-April 2023)

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2018-19	1,261,365	5,676,913	22%
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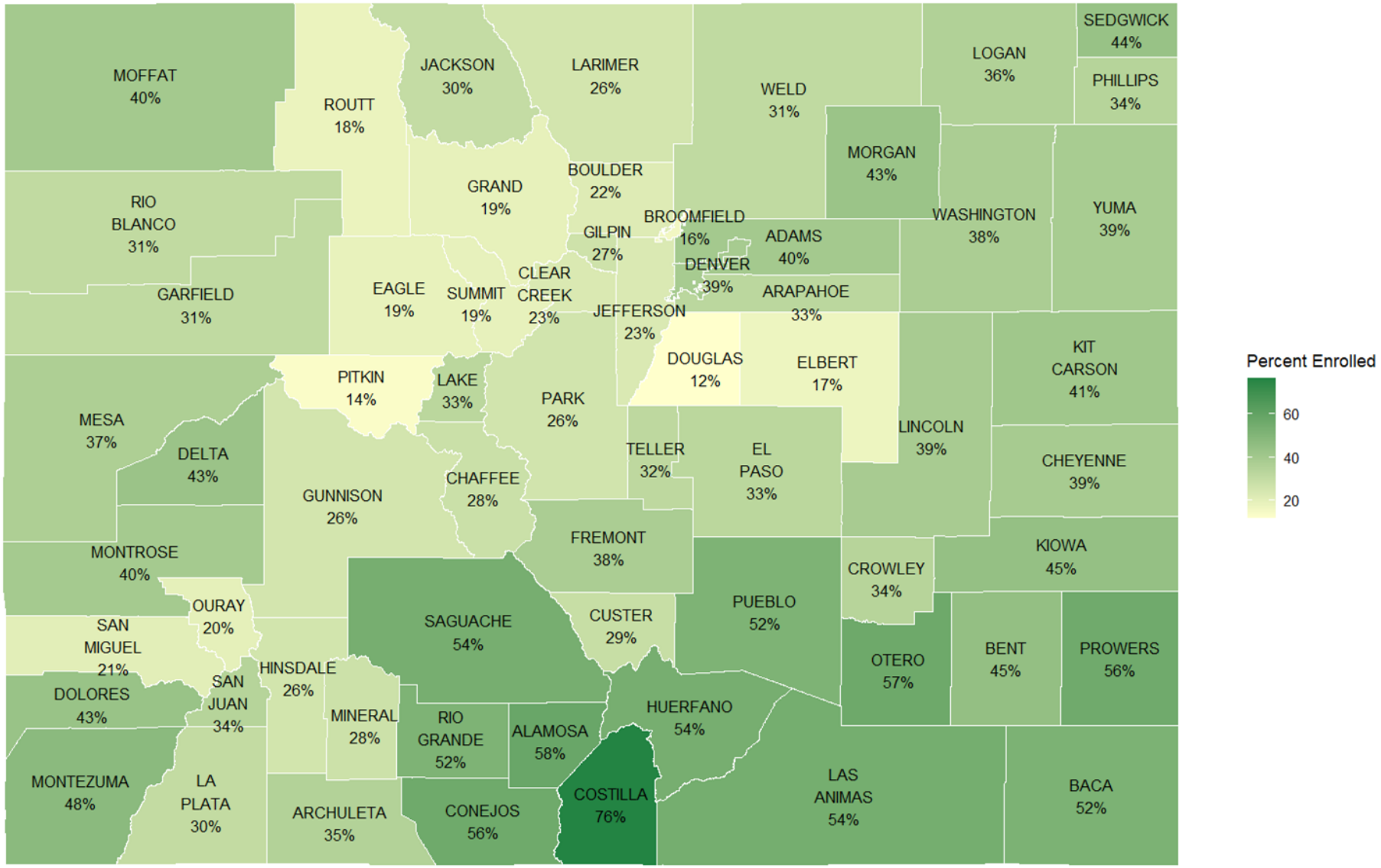
Question 5: Medicaid Enrollment % of County Population (2022 data)



Question 6-7: Minimizing Disenrollments, Supporting Long-Term Services & Supports (LTSS) members through unwind

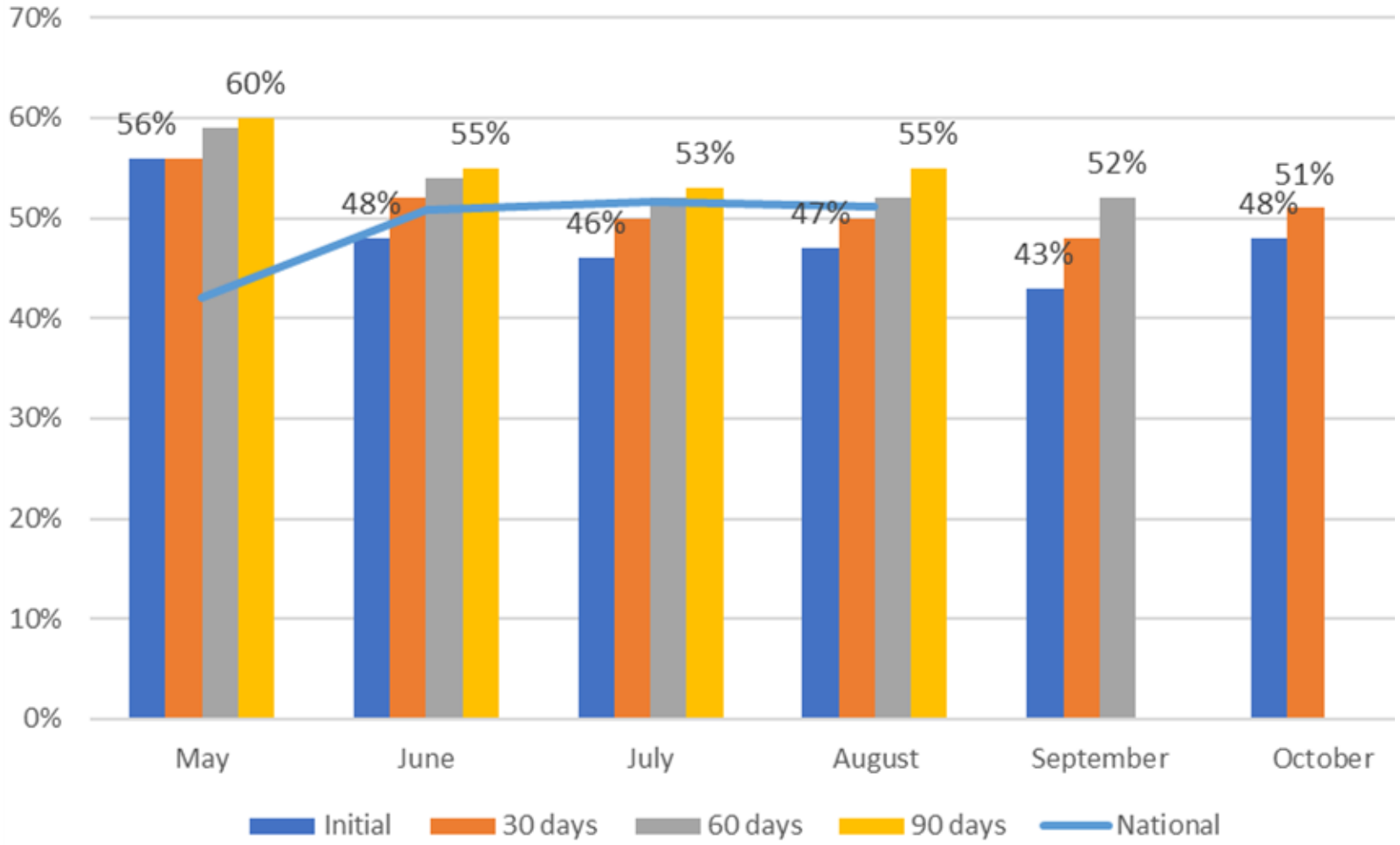
- **Renewal packet return rate** increased for non-Modified Adjusted Gross Income (MAGI) since start of unwind from 46% to 65%
- **Redesigned renewal packets -** 33% shorter, Colorado State seal
- **Ex parte at individual level**, reinstated 7,510 retroactively affected by change
- **60-day extension for vulnerable populations through June 2024**
  - Long-term care, members on waivered services, buy-in
  - Additional outreach from new Outbound Contact Center
  - Members have 60 day extension + 90 day reconsideration period to complete renewal
  - Created streamlined escalation process
  - Website LTSS specific resources - LTSS FAQ page and LTSS one-pager
- **4 outreach toolkits** - developed with members and advocates, translated into top 11 languages, statewide PSA campaign in partnership with C4
- **Massive partnership with providers and stakeholders**
- **Improved digital tool** (PEAK), correspondence improvement projects
- **Contracting with MA sites to work renewal backlogs and support counties**
- **Working with nursing facilities** to provide data on members needing more support
- **Reduced "whereabouts unknown"** 26% to 6% with eligibility system processing improvements, consolidated Return Mail Center, and collaboration with partners

Question 8: National Comparisons - Colorado made it a top priority to get people who lost their jobs during COVID induced economic downturn onto Medicaid

Date	National (In Millions)	% Change month	% Change aggregated	National Unemployment Rate	HCPF (In Millions)	% Change month	% Change aggregated	CO Unemployment Rate
Jan-20	70.97			3.5%	1.28			3.0%
Jul-20	75.72	6.69%	6.7%	10.2%	1.37	7.64%	7.6%	6.4%
Jan-21	80.59	6.43%	13.6%	6.3%	1.49	8.46%	16.7%	6.3%
Jul-21	83.77	3.95%	18.0%	5.4%	1.56	4.62%	22.1%	5.6%
Jan-22	86.98	3.83%	22.6%	4.0%	1.62	4.22%	27.3%	4.0%
Jul-22	89.82	3.27%	26.6%	3.5%	1.70	4.71%	33.3%	2.7%
Jan-23	92.97	3.51%	31.0%	3.4%	1.79	5.34%	40.4%	2.8%
Jul-23	91.51	-1.57%	28.9%	3.5%	1.72	-3.85%	35.0%	2.9%

NOTE: This chart does not include retroactivity

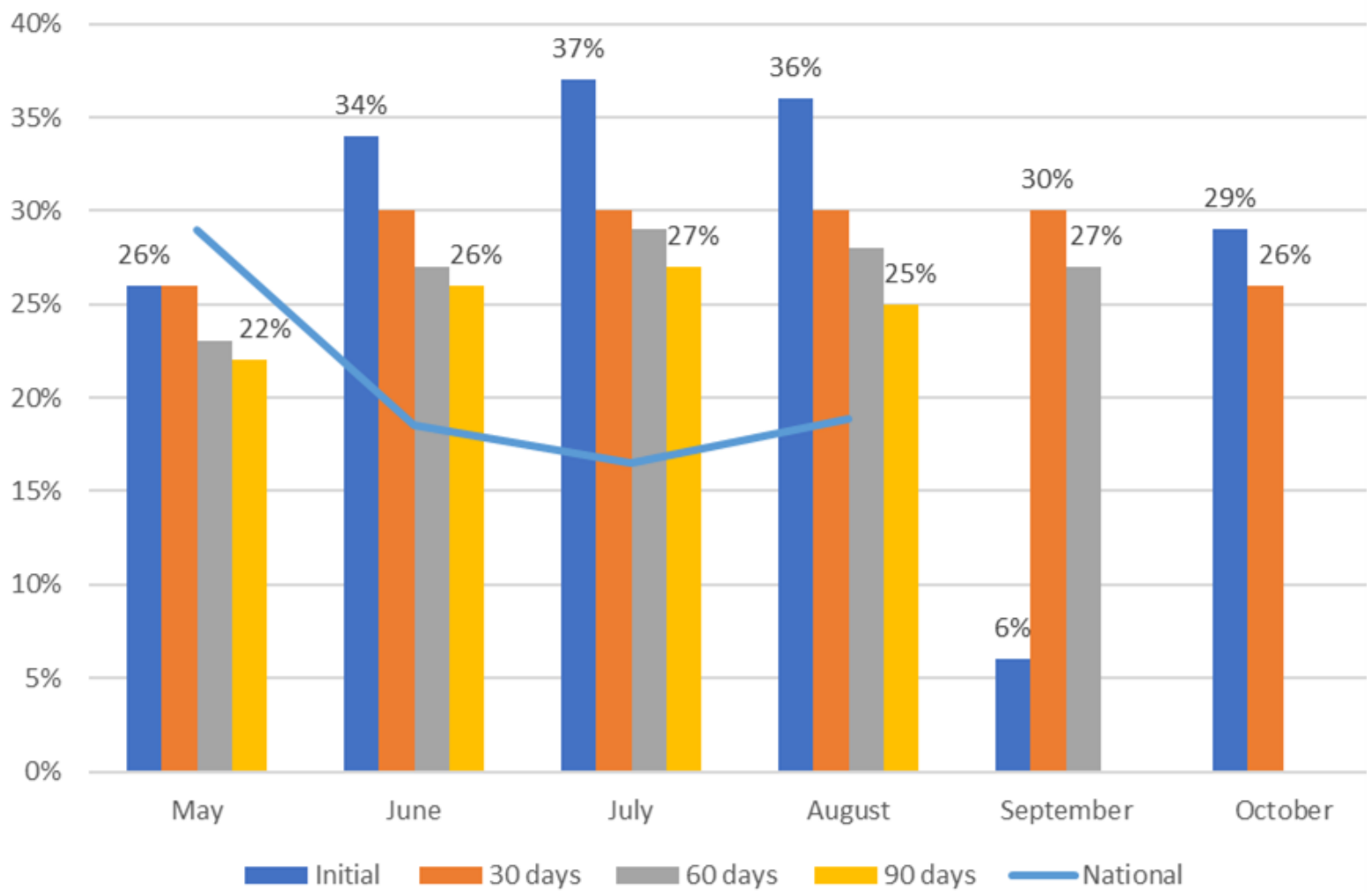
Question 8: Renewal rate improves over 90 day reconsideration period



Question 8: Colorado PHE Unwind Compared to Historic

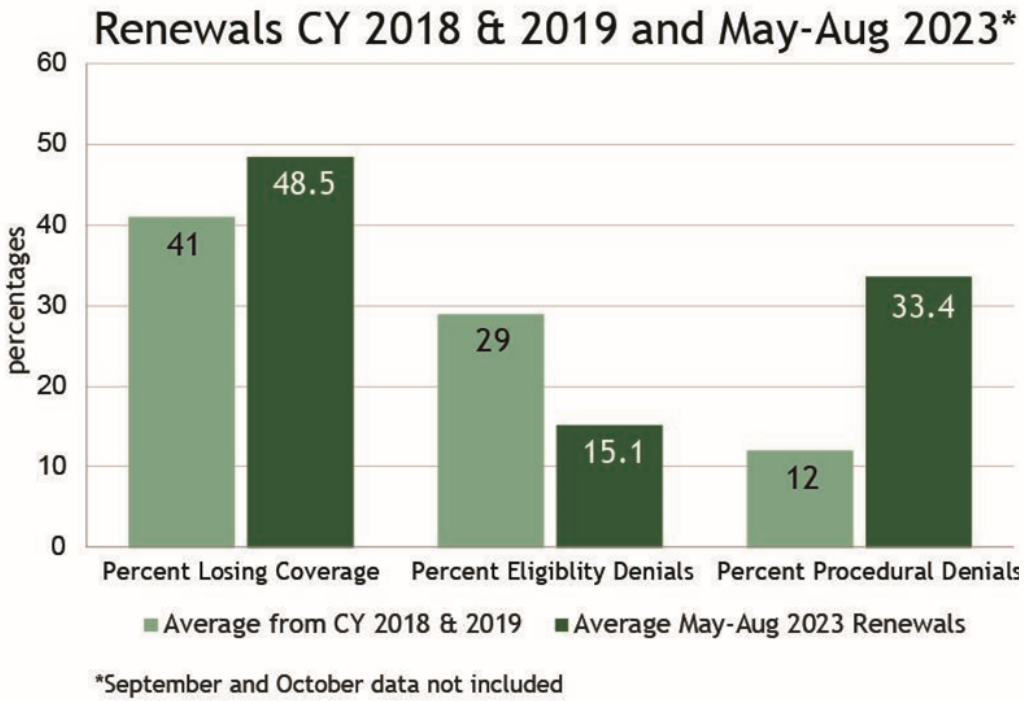
- **Colorado's 57% pre-pandemic (calendar year 2018 and 2019) average renewal rate** closely aligns with Colorado's PHE Unwind average renewal rate of about 55% (based on May 2023 through August 2023, including the 90 day reconsideration period)
- **Colorado's 41% pre-pandemic (calendar year 2018 and 2019) average disenrollment rate** closely aligns with Colorado's PHE Unwind average disenrollment rate of about 43% (based on May 2023 through August 2023, including the 90 day reconsideration period)

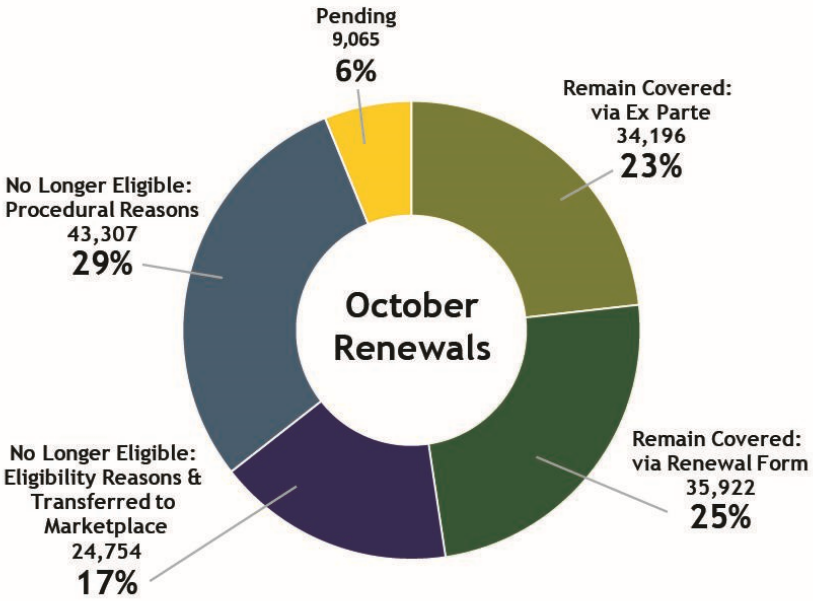
Questions 8-9: Procedural denials drop after the 90 day reconsideration period



Our procedural denials will be higher than the national average because our pending rate is so low (historically 1-3% vs national 20%+).

Question 9: Procedural denials





Based on pre-pandemic data, on average about half of those losing coverage become eligible for Medicaid again within two years. More information at https://hcpf.colorado.gov/ccu

Questions 10-18: County Administration

SB 22-235 - Year 1 Report Recommendations Overview

Transformative Recommendation #	Transformative Recommendation
Transformative Recommendation 1	Develop service delivery standards for public and medical assistance programs
Transformative Recommendation 2	Make work accessible and portable
Transformative Recommendation 3	Improve hiring and retention practices
Transformative Recommendation 4	Optimize PEAK
Transformative Recommendation 5	Improve policy documentation and dissemination
Transformative Recommendation 6	Continue with improvements to the current training model

Quick Win #	Quick Win
Quick Win 1	Create opportunities for state and county collaboration
Quick Win 2	Increase communication and collaboration between CDHS and HCPF
Quick Win 3	Align administrative requirements

Year 2 Report includes Funding Model due in November 2024.

Questions 19-22: Appeals

The Health First Colorado appeals process has seven steps:

1. Send your request for a formal hearing or expedited (faster) hearing to the Office of Administrative Courts.
2. Office of Administrative Courts sets hearing date.
3. Prepare for the hearing.
4. Attend the hearing.
5. Get the judge's initial decision.
6. What to do if you disagree with the judge's initial decision.
7. Get the final agency decision.

Up to 90 days to complete the process (can take longer if a member requests schedule change). Untimely appeals have declined with support from temporary PHE appeals staff.

Value Based Payments Questions 23-30

Value Based Payments Questions: 23-28

Value based payments:

- Move us from paying for volume to paying for value
- Support improving access, member outcomes (quality), closing health disparities (equity), control costs
- Support providers in their transition away from fee for service through innovations and tools, to help them achieve shared goals and earn value based payments while stabilizing their revenue
- Manage total cost of care through a longer term vision, keeping people healthy while addressing chronic health concerns and social determinants of health
- Help pay for a more coordinated, team based care delivery model (case management, coaching, care coordination, connection to supports)

Questions 29-30: VBP for BH Safety Net Providers

Comprehensive Community Behavioral Health Provider

Provide care coordination and **all of the following services**:

- Emergency/Crisis
- Outpatient SUD and MH
- Intensive Outpatient
- Recovery Supports
- Care Management
- Outreach, Engagement, Education
- Outpatient Competency Restoration

Eligible for cost-based **Prospective Payment System** (PPS) from HCPF July 1, 2024.

Essential Behavioral Health Safety Net Provider

Provides care coordination and **one or more** of the following services:

- Emergency/Crisis
- Outpatient SUD and/or MH
- Intensive Outpatient
- Residential
- Withdrawal Management
- Inpatient
- Integrated Care

Eligible for **Enhanced Rates Model** from HCPF July 1, 2024.

Questions 29-30

HCPF

Contracts with RAEs

- State pays incentives to the RAEs for meeting quality outcomes (KPIs, BHIP Measures)
- Based on national metrics, essential for benchmarking
- HCPF requires RAEs to pay safety net providers based on BHA approved safety net status
- State shares tools, data, TA support

RAEs

Pay providers

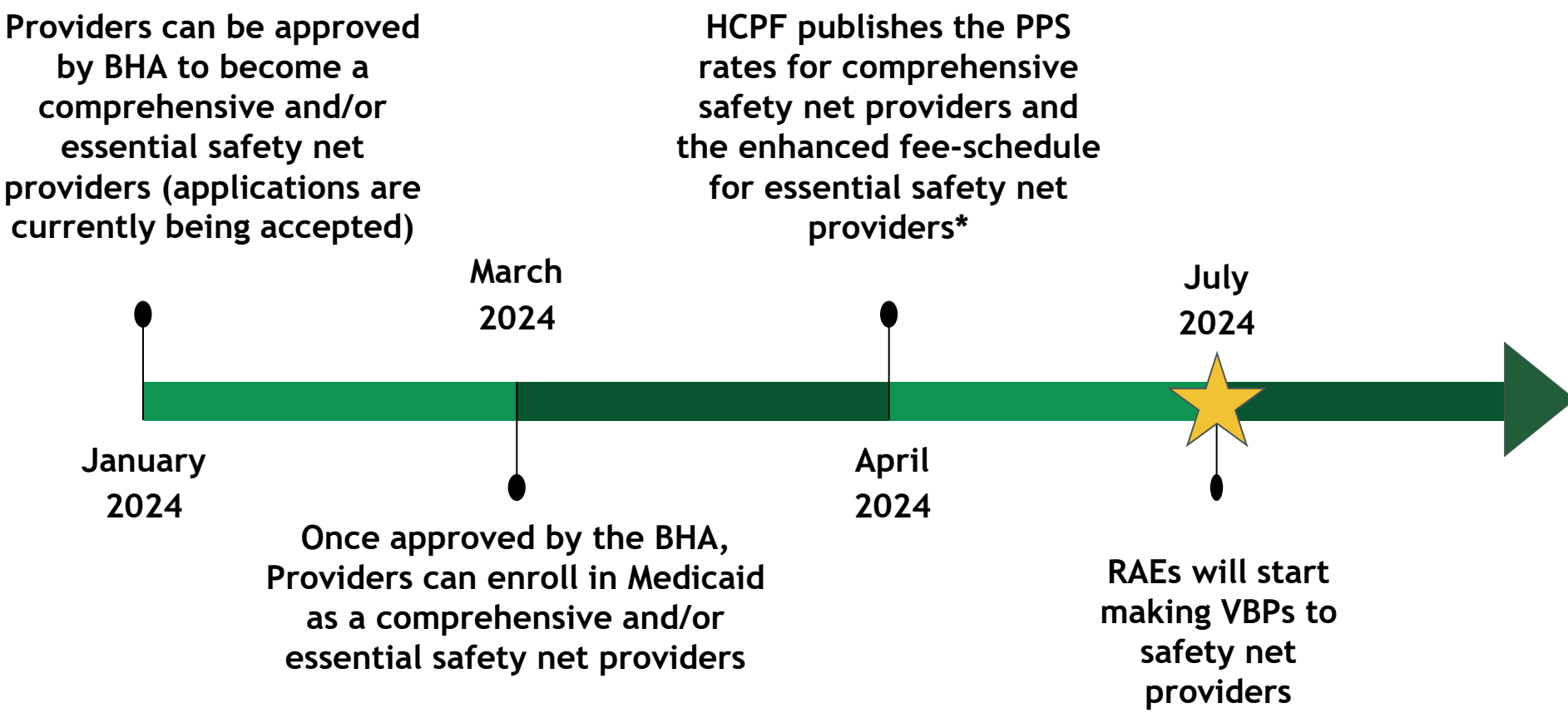
- RAEs pay Safety Net Providers based on statewide approved model, developed with BHA/HCPF
- RAEs provide technology, tools, technical assistance, and data with providers to measure regional success
- Creates additional value-based payment arrangements based on needs of the region

Providers

Serves patients

- Creates plans and policies to meet incentive goals and shared payments with the RAEs
- Sets budgets based on sustainable and flexible cost models or enhanced rate schedules

Questions 29-30: Implementation Timeline for Value Based Payments



*New comprehensive providers will receive a "statewide PPS" rate until their cost reporting can be completed

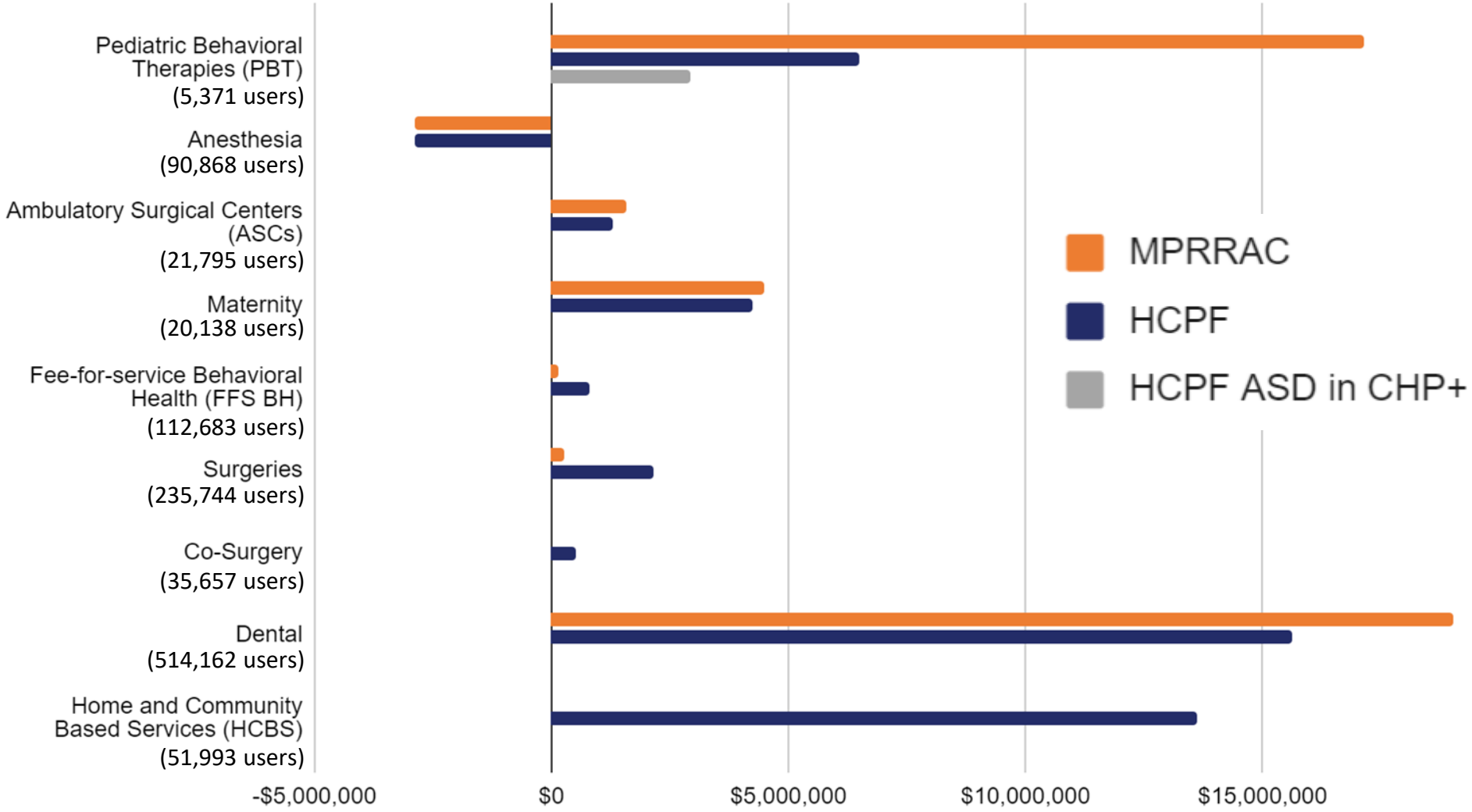
Provider Rates Questions 31-48

Questions 31-32
2023 MPRRAC Review – Overall Fiscal Impact

	MPRRAC	HCPF	Difference	HCPF HCBS Off Cycle Increase	Total HCPF	HCPF Difference
Total Fund	$144,027,428	$112,395,679	($31,631,749)	$53,856,751	$166,252,430	+ $22,225,002
General Fund	$39,718,024	$28,271,871	($11,446,153)	$13,605,949	$41,877,820	+ $2,159,796

- However, HCPF provider rate increases also include HCBS Direct Care workforce base wage increase
- Not shown, HCPF is also adding Autism Spectrum Disorder (ASD) treatment services for CHP+ (additional investment: $13.9M TF, $2.9M GF)

Questions 33-34: General Fund Difference



*Items reviewed by MPRRAC with rate adjustments of <$200 General Fund not listed; FY 2024-25 impact is lower due to cash flow adjustment

Questions 35-38: HCBS Direct Care workforce base wage challenges

Current starting wages in the Denver metro area as of 9/7/23 research		
Amazon	$15-$19.10	Warehouse specialist (fulfilling orders) starting pay in Colorado per Amazon website
McDonalds	$14-$19	Cashier ($14-$19 for Crew Member) starting pay in CO per Glassdoor
King Soopers	$14-$20	Cashier/Front End starting pay in Denver area per their website
Walmart	$15-$20	Cashier/Front End starting pay in CO per Glassdoor
FedEx	$14-$19.10	Package handler to courier starting pay in CO per Indeed

- HCBS is not on the MPRRAC list this year. HCPF is suggesting a shared, multi-year strategy to address HCBS worker shortage, which was 82% workforce turnover pre-pandemic.
- CO is 2nd fastest growing state for older adults; HCBS serves and supports the bulk of our covered individuals with disabilities.
- HCBS base wage now $15.75/hour. That would increase to $16.55/hr through this recommendation.
- HCPF recommendation covers HCBS to match Denver min. wage, rising from $17.29/hr to $18.29/hr effective 1/1/24. (Cost to cover = $2.3M GF. Every $0.10 of non-Denver base wage increase $1.4M GF.) Consideration: Look for more municipal wage adjustments to come.

Questions 39-41: Future review

2024 Review	2025 Review
Home and Community Based Services Waivers	Physician Services
Home Health Services	Dialysis and Nephrology Services
Pediatric Personal Care	Durable Medical Equipment
Private Duty Nursing (No Medicare Coverage)	Physical Therapy and Occupational Therapy and Speech Therapy
Emergency and Non-emergent Medical Transportation	Laboratory and Pathology Services
FFS BH SUD Services	Prosthetics, Orthotics and Disposable Supplies
Physician - Sleep Studies	Eyeglasses and Vision
Psychiatric Residential Treatment Facilities	Injections and other Miscellaneous J-Codes
Qualified Residential Treatment Programs	Targeted Case Management
Dental Services	

Questions 42-43: Historical Across-the-Board (ATB) rate increases

- HCPF is 38% of operating TF budget, 31% of GF.
- From FY 2010-11 through FY 2023-24, the average Medicaid ATB rate increase was 0.9%.
- ATB rate increases were higher in the last three years due to an unusual influx of federal stimulus funding. Prior to this unusual period of federal stimulus, the average was about 0.5% per year.
- FY 2024-25 returns the state to typical budget cycles. Given the ATB history, a 1% ATB (double the 0.5% historic average) is what HCPF is recommending, given inflationary challenges.
- **Every 1% ATB costs $29M GF.**

Fiscal Year	ATB
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%

Questions 44-46: Targeted rate increases

Fully Annualized Impact	Total Funds	General Fund	Unique Users FY 2021-22
Pediatric Behavioral Therapies	$13,019,386	$6,509,693	5,371
Anesthesia	($9,897,967)	($2,896,344)	90,868
Ambulatory Surgical Centers (ASCs)	$4,366,634	$1,277,764	21,795
Maternity	$8,494,404	$4,247,202	20,138
Behavioral Health FFS	$1,644,157	$822,078	112,683
Surgeries	$7,389,047	$2,162,184	235,744
Co-Surgeries	$1,759,670	$514,915	35,657
Dental	$85,620,023	$15,634,217	514,162
Total Impact	**$112,395,679**	**$28,271,871**	(some members receive multiple services)

Questions 47-48: Methodology

- The Department used a statistical methodology to establish whether any of the states used in the comparison were mathematical outliers.
  - The Department used this methodology to examine other states' rates across all service categories in the development of the benchmark rates.
  - The Department removed high statistical outliers in developing benchmark rates for certain surgeries and abortion services.
- For pediatric behavioral therapy rates, Nebraska was the only mathematical outlier.

Denver Health Questions 49-52

Questions 49-52
Denver Health Financials

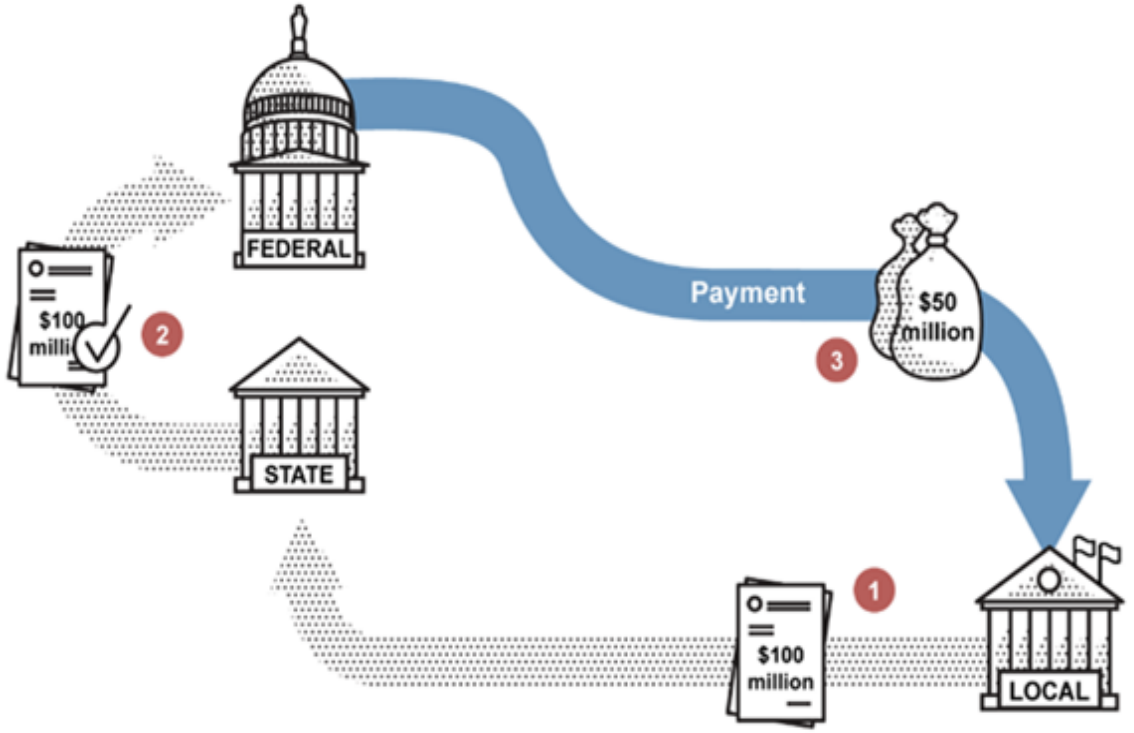
System	Calendar Year	Days Cash on Hand	Reserves
Denver Health	2019	131	$364 M
	2020	159	$441 M
	2021	117	$381 M
	2022	87	$302 M
	2023 Q1, 2 & 3	82	$297 M

System	Calendar Year	Operating Profit Margin	Operating Profit[1]	Total Profit Margin	Total Profit (including investments)
Denver Health	2019	4.8%	$54 M	11.4%	$127M
	2020	-0.1%	($1 M)	9.1%	$99M
	2021	-0.8%	($9 M)	1.2%	$15M
	2022	-1.9%	($24 M)	-4.4%	($57 M)
	2023 Q1,2& 3	0.2%	$3 M	0.8%	$8 M

General Financing Questions 53-58

Question 55: Example of a State Medicaid Payment Financed Using Certified Public Expenditures and Federal Funds

1. A local government provides Medicaid services and submits a CPE of $100 million to the state Medicaid agency for the costs of services.
2. The state reports the $100 million CPE to the Centers for Medicare & Medicaid Services.
3. Federal government provides matching federal funds in the amount of $50 million.[a]



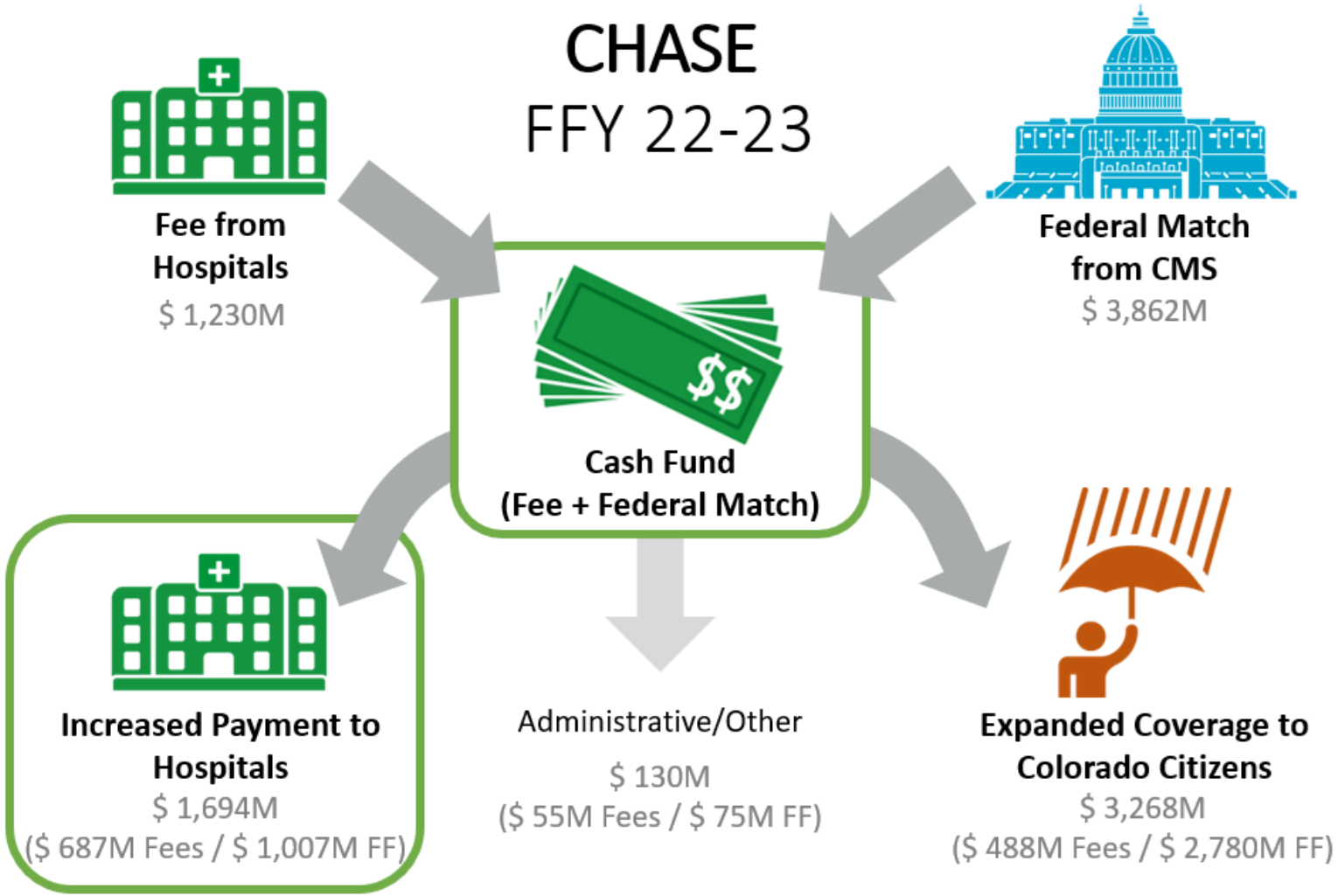
BOTTOM LINE

Federal government spent **$50 million.**
State spent **$0** in state general funds.
Local government spent **$100 million.**
Net effect on the local government: The local government spent a net of **$50 million**.

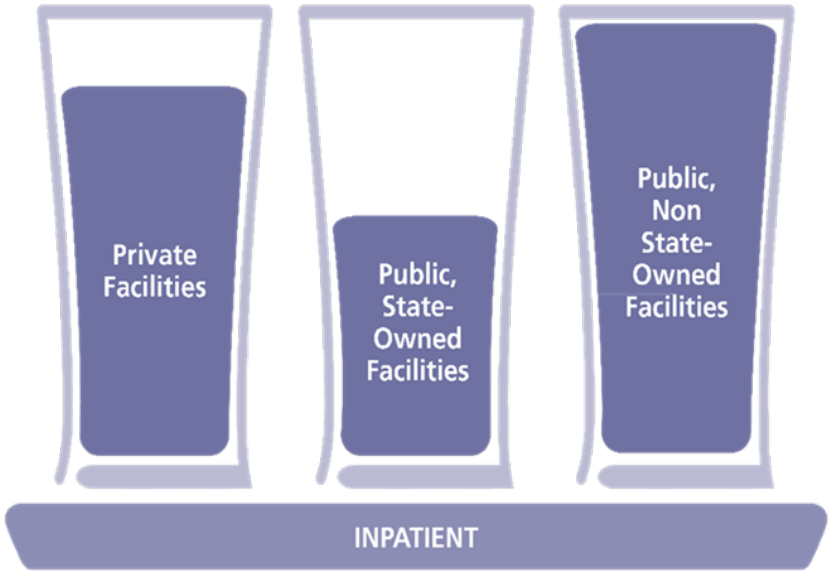
Federal share (federal government)

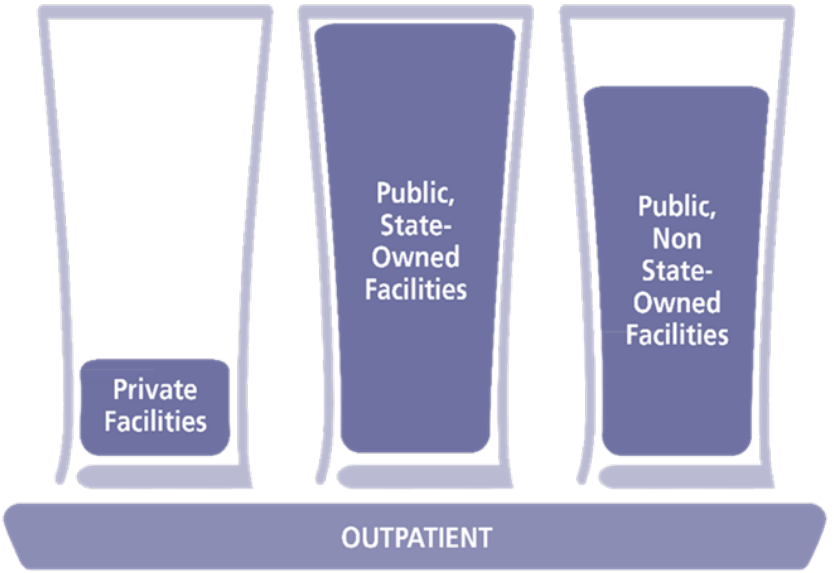
Source: Government Accountability Office, Medicaid Primer on Financing Arrangements, July 14, 2020. gao.gov/assets/gao-20-571r.pdf

Question 56

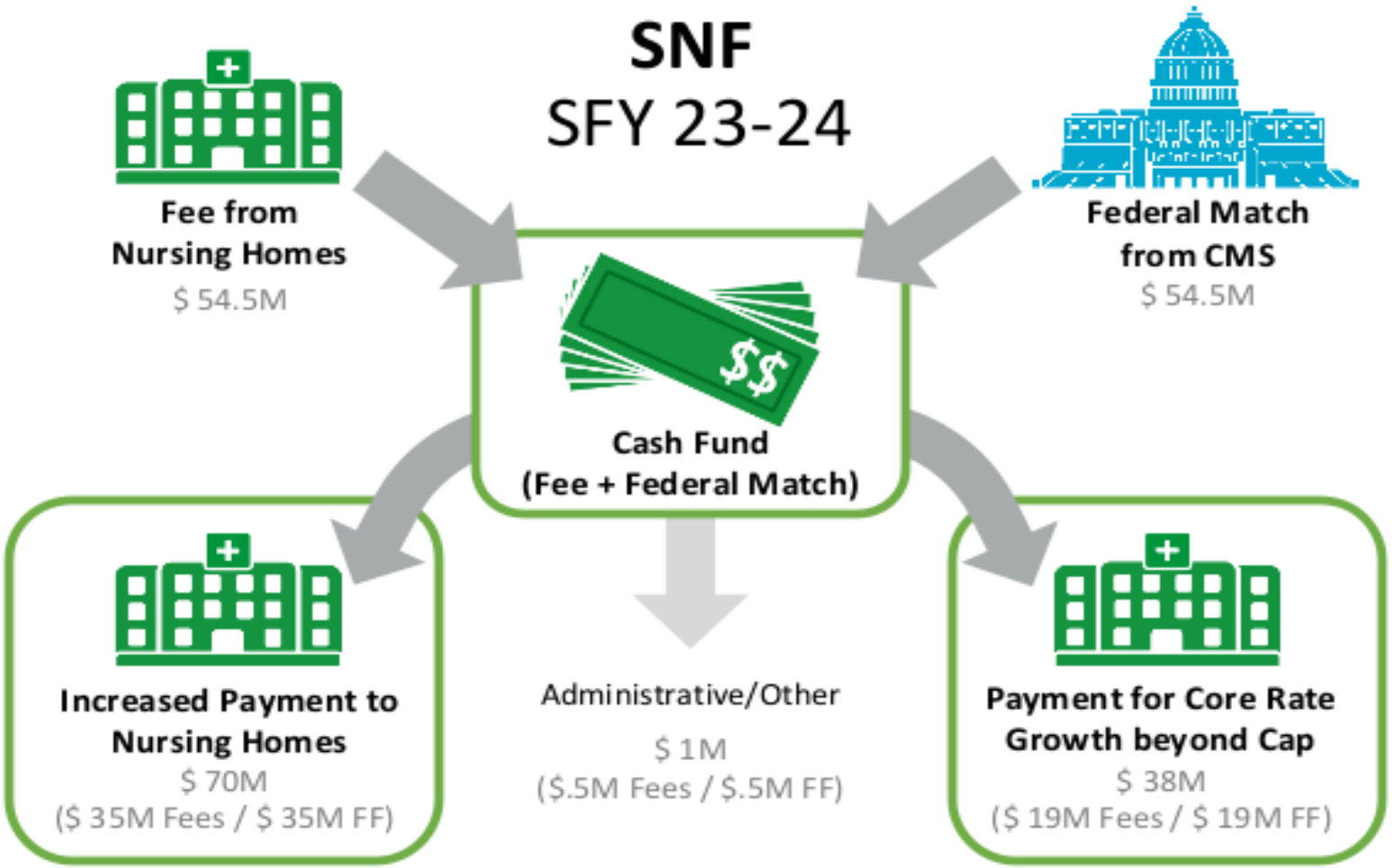

CHASE
FFY 22-23
Fee from Hospitals
$ 1,230M
Federal Match from CMS
$ 3,862M
Cash Fund (Fee + Federal Match)
Increased Payment to Hospitals
$ 1,694M
($ 687M Fees / $ 1,007M FF)
Administrative/Other
$ 130M
($ 55M Fees / $ 75M FF)
Expanded Coverage to Colorado Citizens
$ 3,268M
($ 488M Fees / $ 2,780M FF)

Question 56: Hospital Upper Payment Limits





Questions 57-58: SNF Supplemental Payments



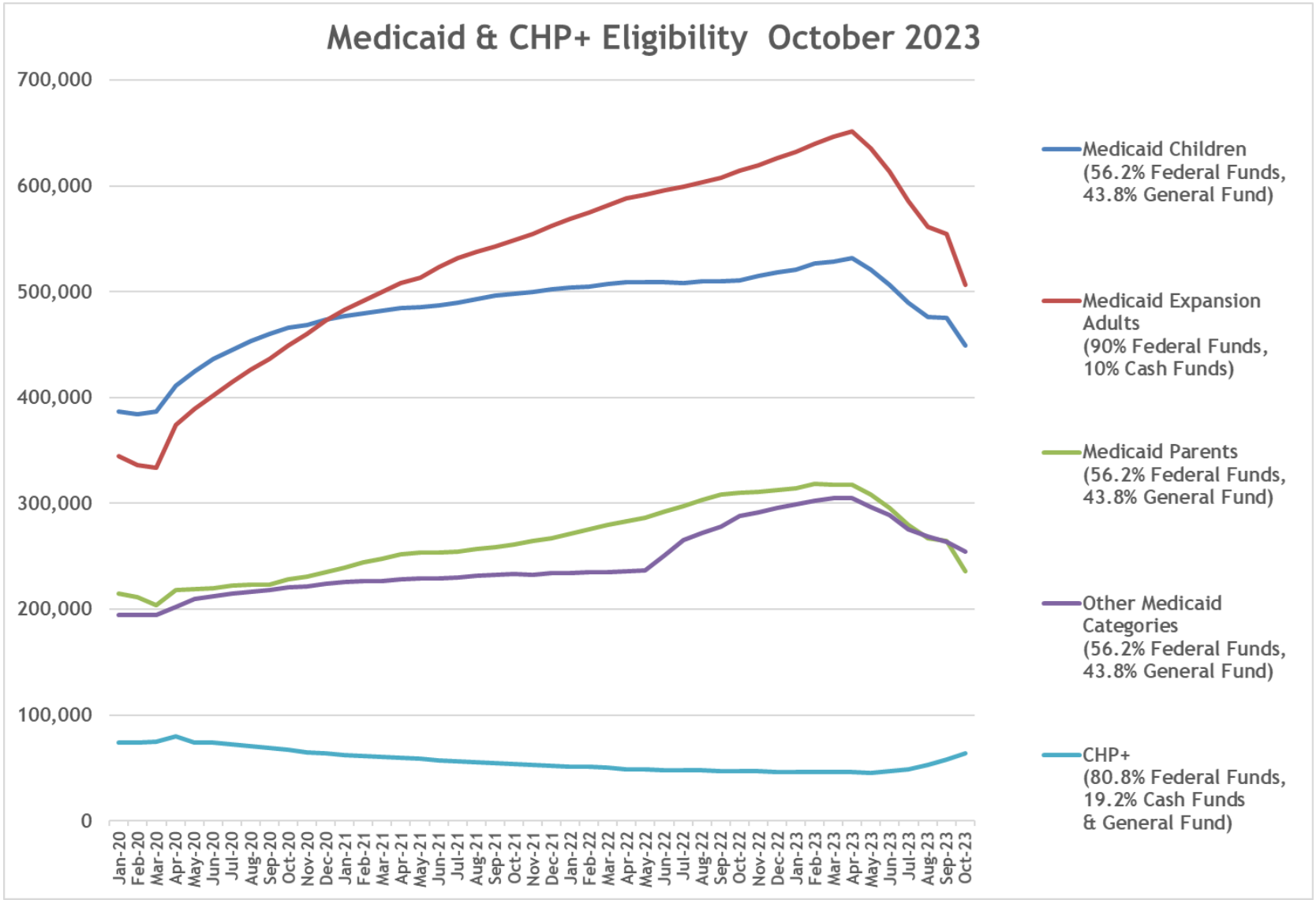
R12-14 and General Eligibility Questions Questions 59-67

Child Health Plan *Plus* Benefit Questions 68-70

Questions 68-69: CHP+ and Medicaid Differences

	CHP+	Medicaid
Authority	Title XXI of the SSA	Title XIX of the SSA
Federal Matching	65%	50% children and parents 90% expansion adults
Finance Structure	State spending matched up to a capped allotment	State spending matched with no cap
Eligible Members	Children under 19 and Pregnant People	Children & Adults
Recent Enrollment Numbers[1]	57,406	1,506,863
Income Eligibility as percent of FPL	143%-260%	147% FPL for children 138% FPL for adults under 65 195% FPL for households
Delivery System	Fully capitated managed care 4 managed care organizations, county overlap in Metro Area	Regional Accountable Entities manage capitated behavioral health benefit and care coordination Fee-for-service physical health
Additional Similarities	12-month post-partum expansion 1289 Look-alike program 0$ enrollment fee	

Question 70: Membership impact of COVID and the end of the PHE Continuous Coverage requirement

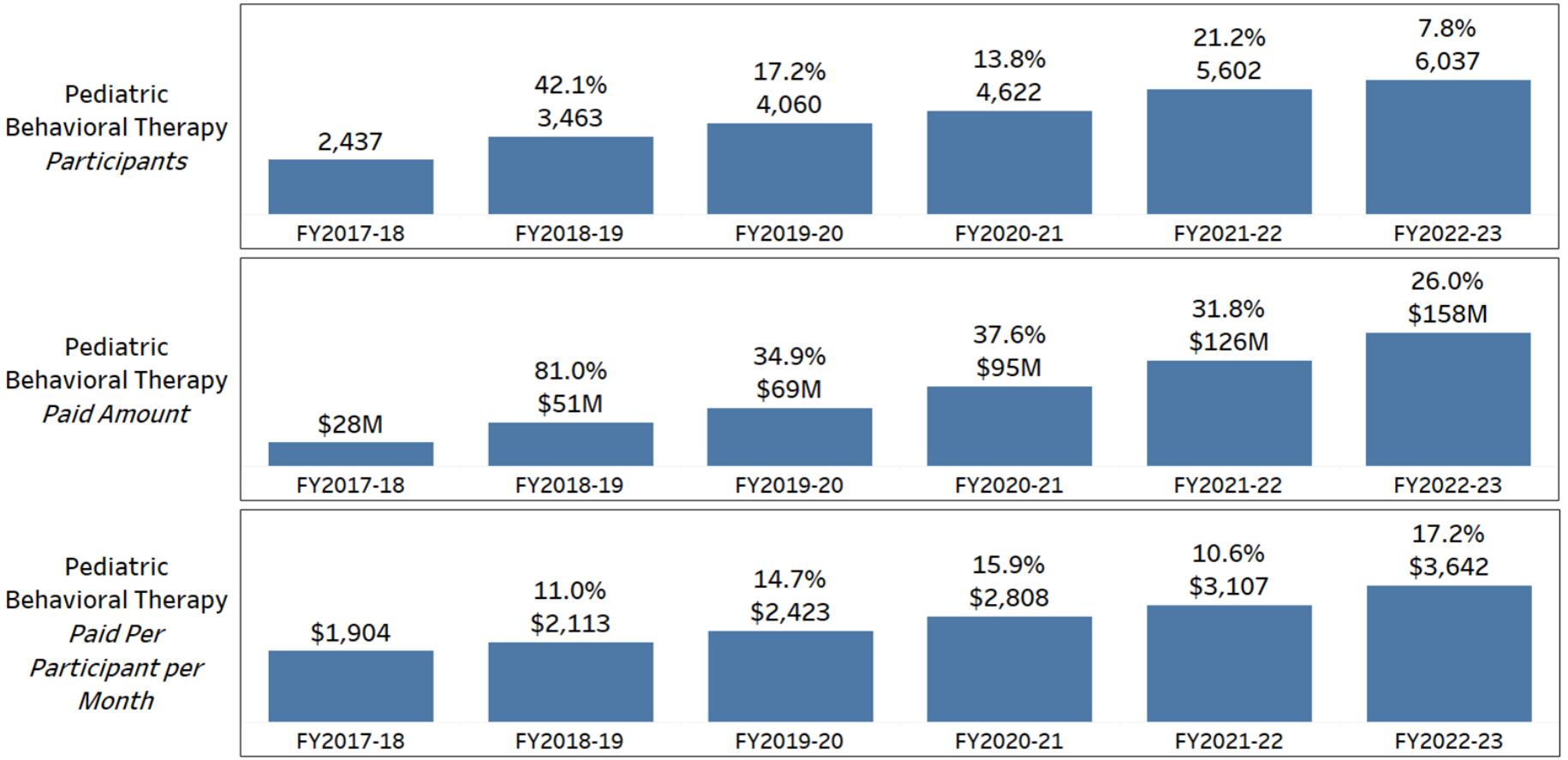


Autism Providers Questions 71-76

Pediatric Behavioral Therapy (PBT)

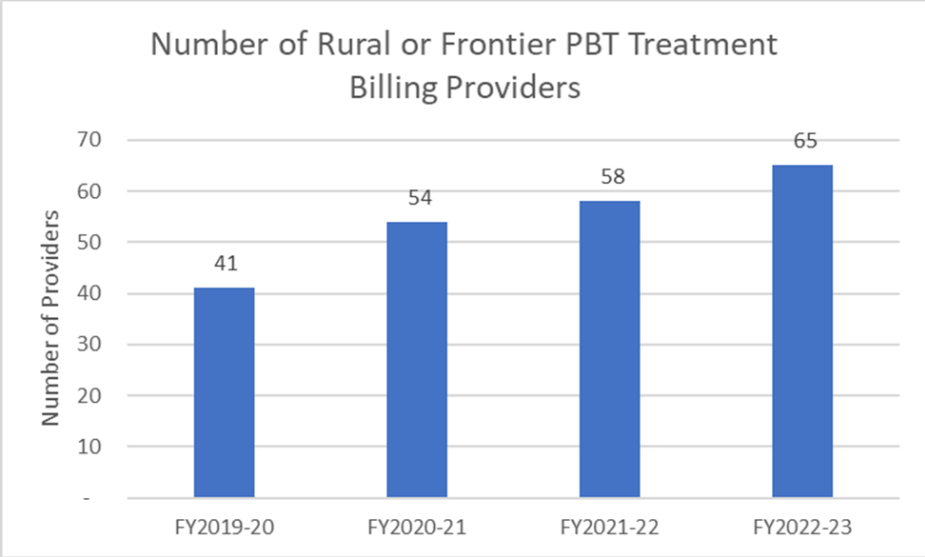
Significant increases in PBT

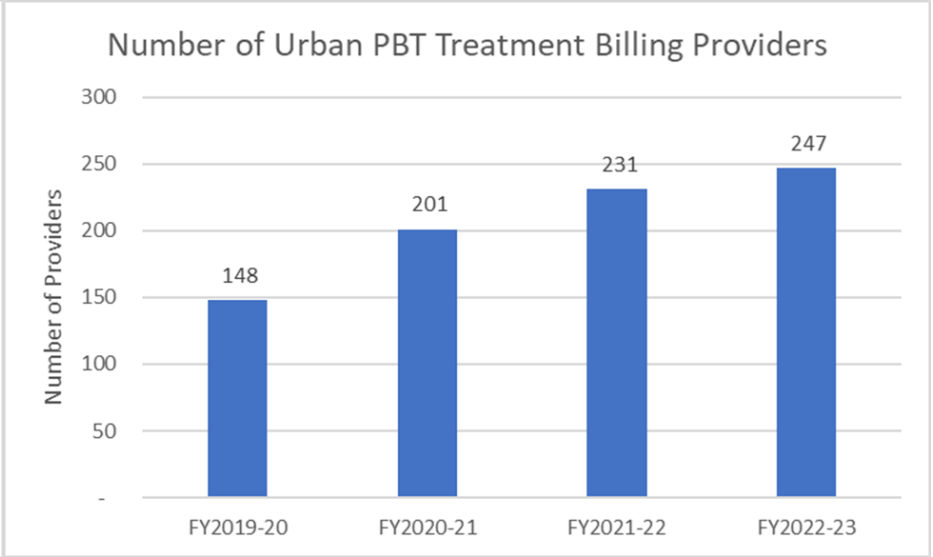
- # of children served more than doubled
- Amt. spent increased fivefold



*The percents on the top are the change from the prior FY

Rural and Urban PBT Providers





Center for Economic and Policy Research June 2023 report on private equity in autism

Office of Community Living

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

Who Receives Long-Term Services & Supports?

13%

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

43%

Adults
ages 21-64

44%

Older Adults
ages 65 or older

Cross Disability

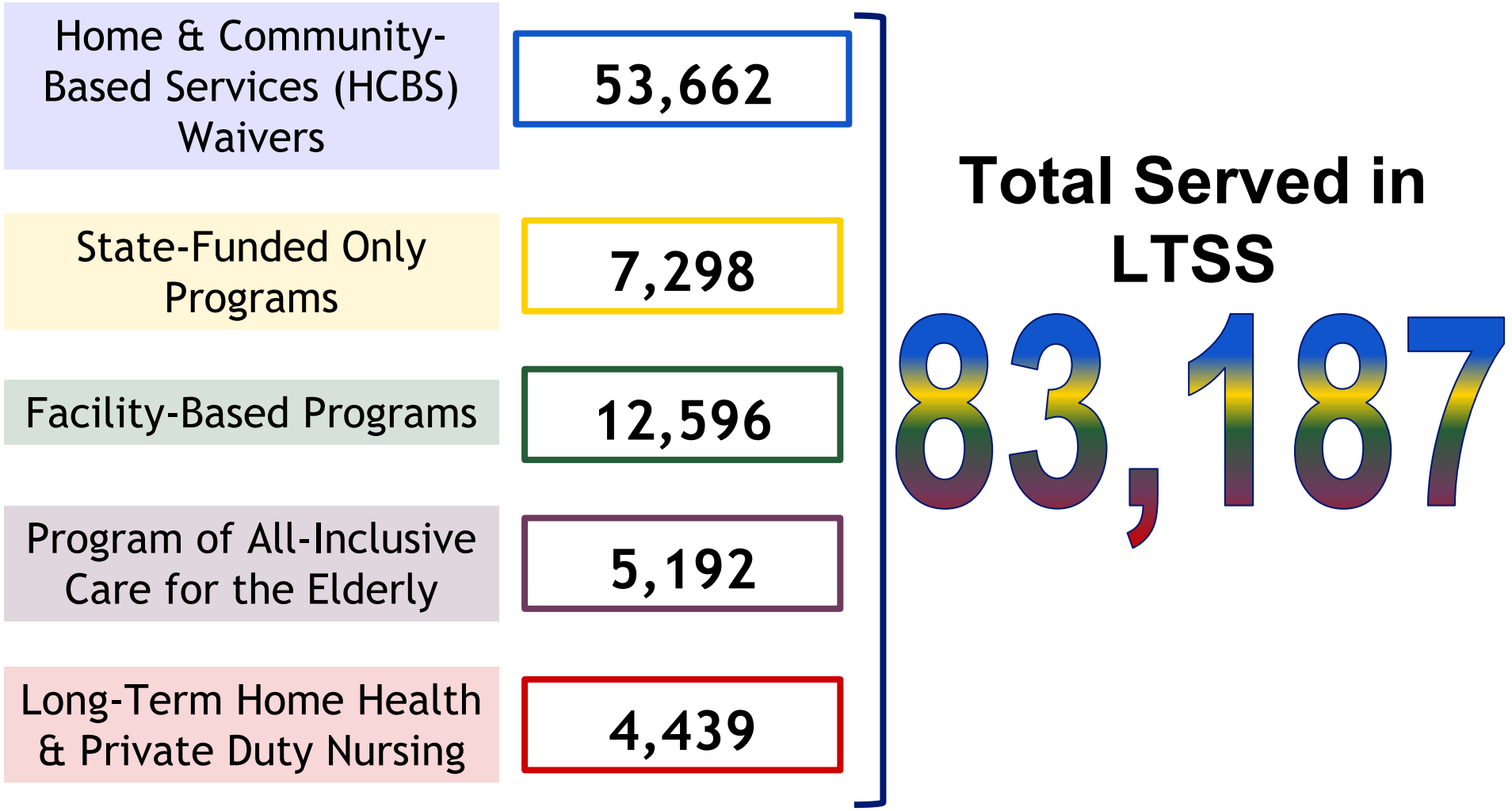
- **Physical Disabilities** - i.e., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - I/DD, Brain Injury, Dementia
- **Mental Health**

86% have a **chronic condition** (compared to 29% of all Medicaid members)

37% have 5 or more chronic conditions

FY 2022-23; Data represent percentage of people receiving Medicaid LTSS in various age groups.

Long-Term Services & Supports Programs



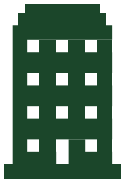
SOURCE: FY 2022-23; based on claims in MMIS.

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

Community-Based Program Growth Questions 77-78

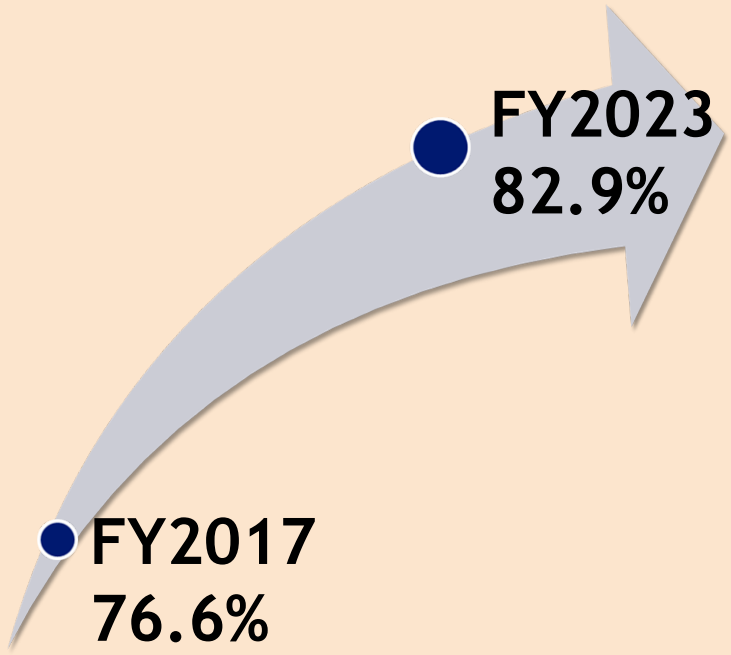
Community-Based Program Growth

Program Growth by HCBS Waiver From FY 2017 – FY 2023

Brain Injury	Children With Life Limiting Illness	Children's Extensive Supports	Children's Habilitation Residential Program	Children's HCBS
+70%	-22%	+67%	+743%	+56%

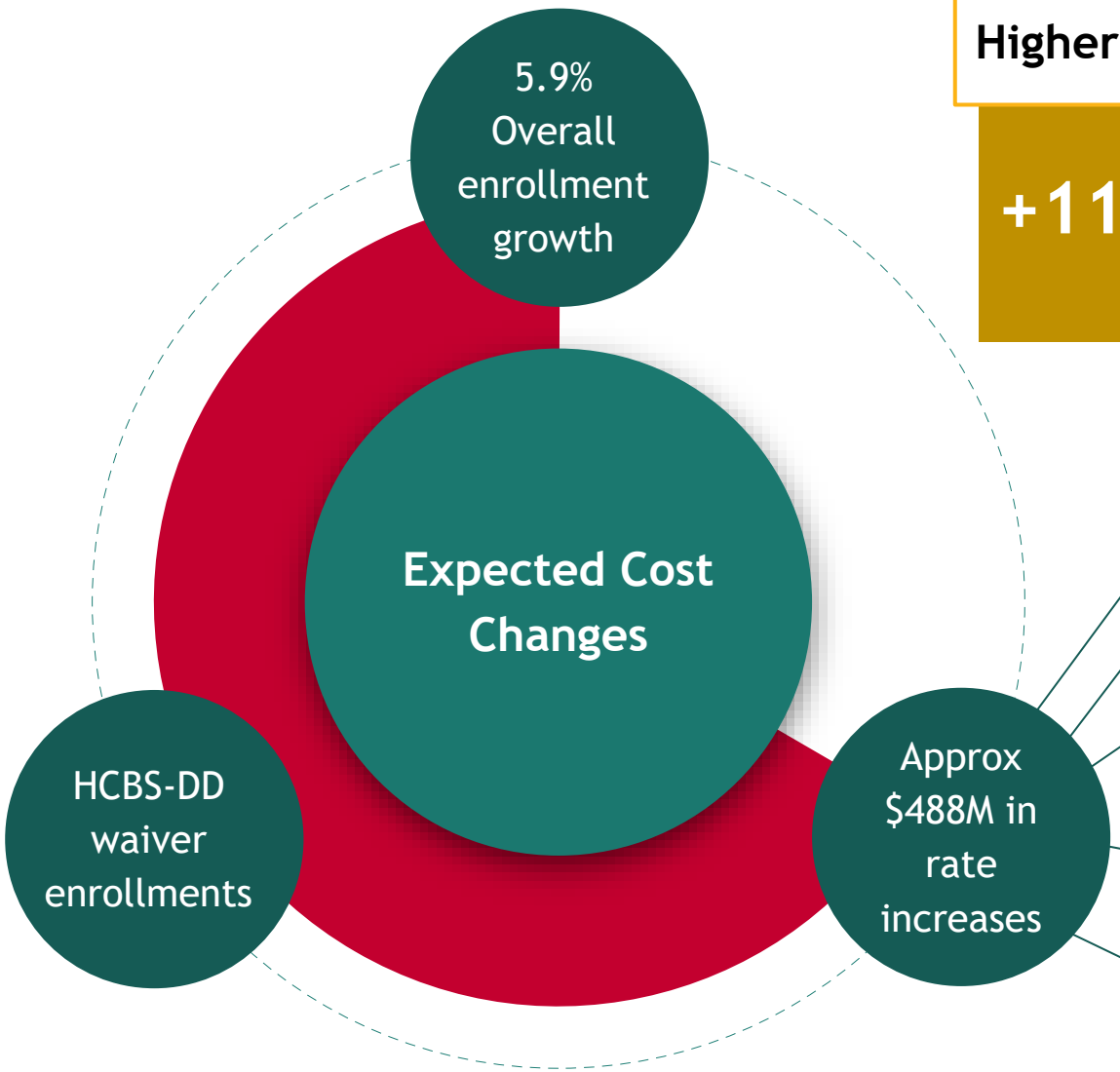
Community Mental Health Supports	Developmental Disabilities	Elderly, Blind, & Disabled	Compl. & Integrative Health	Supported Living Services
+2%	+53%	+15%	+200%	0%

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



LTSS Cost Growth Questions 79-80

FY19-20 to FY22-23 LTSS Cost Growth



Higher than Expected Cost Changes

+115% In Home Support Services expenditures as members have shifted to this service to better meet their needs

- LTSS Base Wage
- Local Minimum wage adjustments
- Across the board provider rate increases
- Targeted rate increases
- Statutorily required rate increases

Strategies for Sustainable Growth

Electronic Visit Verification

Utilization Management

Continued analysis & policy adjustments

Federal financing opportunities in alignment with other states

- Community First Choice
- Money Follows the Person
- ARPA Section 9817

Third Party Assessor
R-10
Questions 81-92

R-10 Third Party Nurse Assessor

R-10

- A request for funding to use a 3rd party nurse **assessor**
- The **assessor** will evaluate members for LTHH, PDN &/or HMA
- The implementation of the new **assessor** can occur with current process/assessment tools

ARPA HCBS

- Development of a new Skilled Care Acuity Tool (assessment tool)
- Funding approved through SB 21-286

The assessment tool is NOT part of the R-10 budget request

New Skilled Care Acuity Tool

(assessment tool)

ARPA Funded

Piloting of the tool in 2024; Implementation 2025

Tool Development
University of Massachusetts Chan Medical School (UMASS) is developing the tool with ARPA HCBS funding

Tool Strengths
Valid & Reliable
Based on research from over 50 state's tools which will objectively evaluate individual needs

Stakeholder Engagement
Began in May 2023 & will continue through 2024. Feedback built into tool development

Can be used with adults or pediatrics

Tool portions are based on the CSN & the PAT

R-10 & New Assessment Work Together

Skilled Care Services	PDN	LTHH	HMA
Assessment (ARPA HCBS)	Unvalidated PDN tool	PAT - children No tool - Adults	LOC/Task Worksheet
	Skilled Care Acuity Tool		
Assessor (R-10)	PDN provider	LTHH provider	Case Manager at CMA
	QIO 3rd Party Nurse Assessor		
URUM	Acentra		Telligen
	Single Contracted Entity		**N/A**

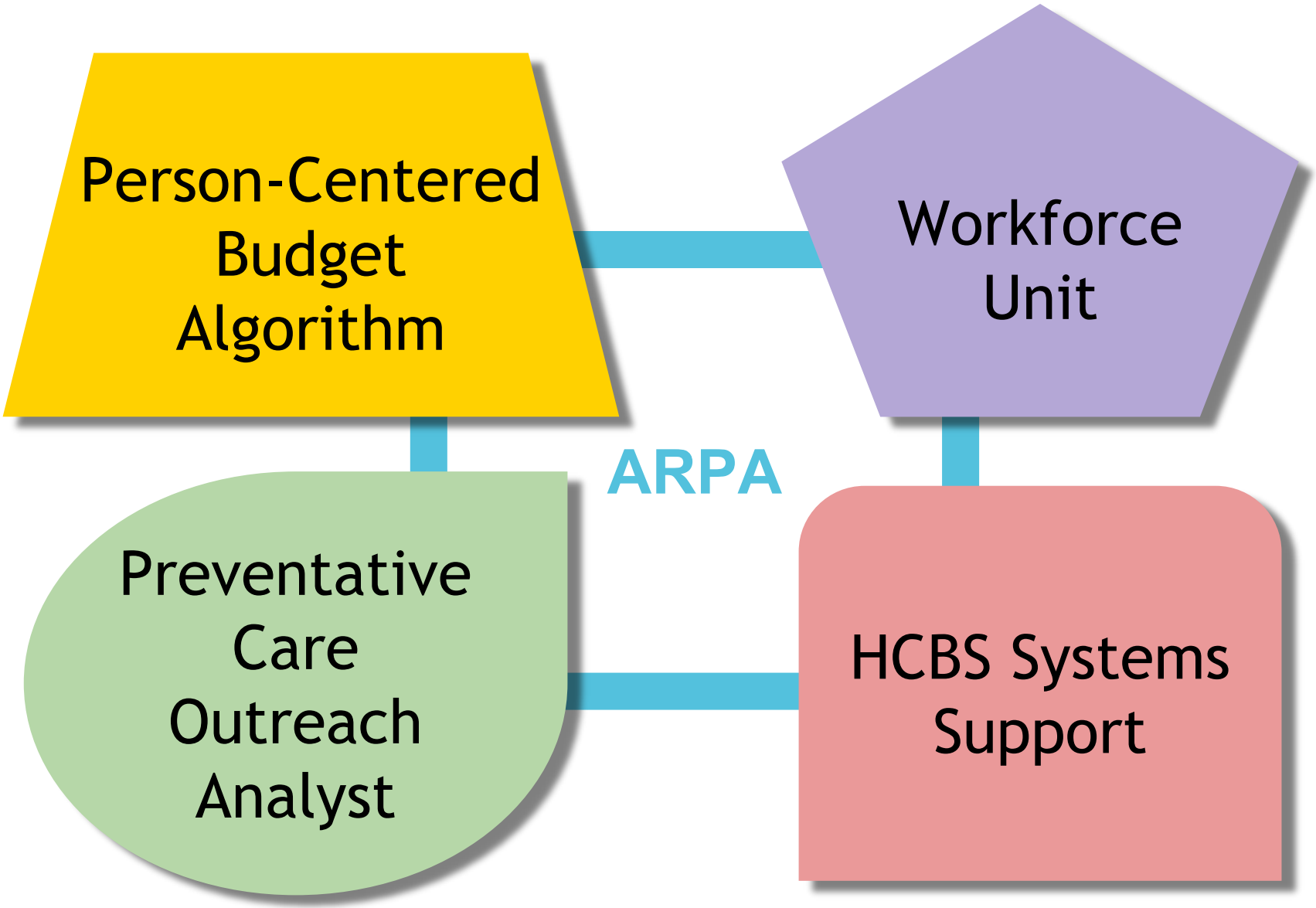
Current State Future State

Goals of R-10: Third Party Nurse Assessor

1	Member Benefits	• Reduced burden on members & their families • Enhanced expertise & education from assessor • Whole-person review- holistically skilled assessment will demonstrate the entirety of a member's needs, including a combination of services
2	Provider Benefits	• Decreased burden in determining appropriate service levels • Ability to provide scope of services with one assessment • Equitable service delivery across agencies
3	HCPF Benefits	• 75% cost match by using a QIO • Mitigate overlapping utilization & duplication across modalities of service • Eliminate potential provider conflict of interest

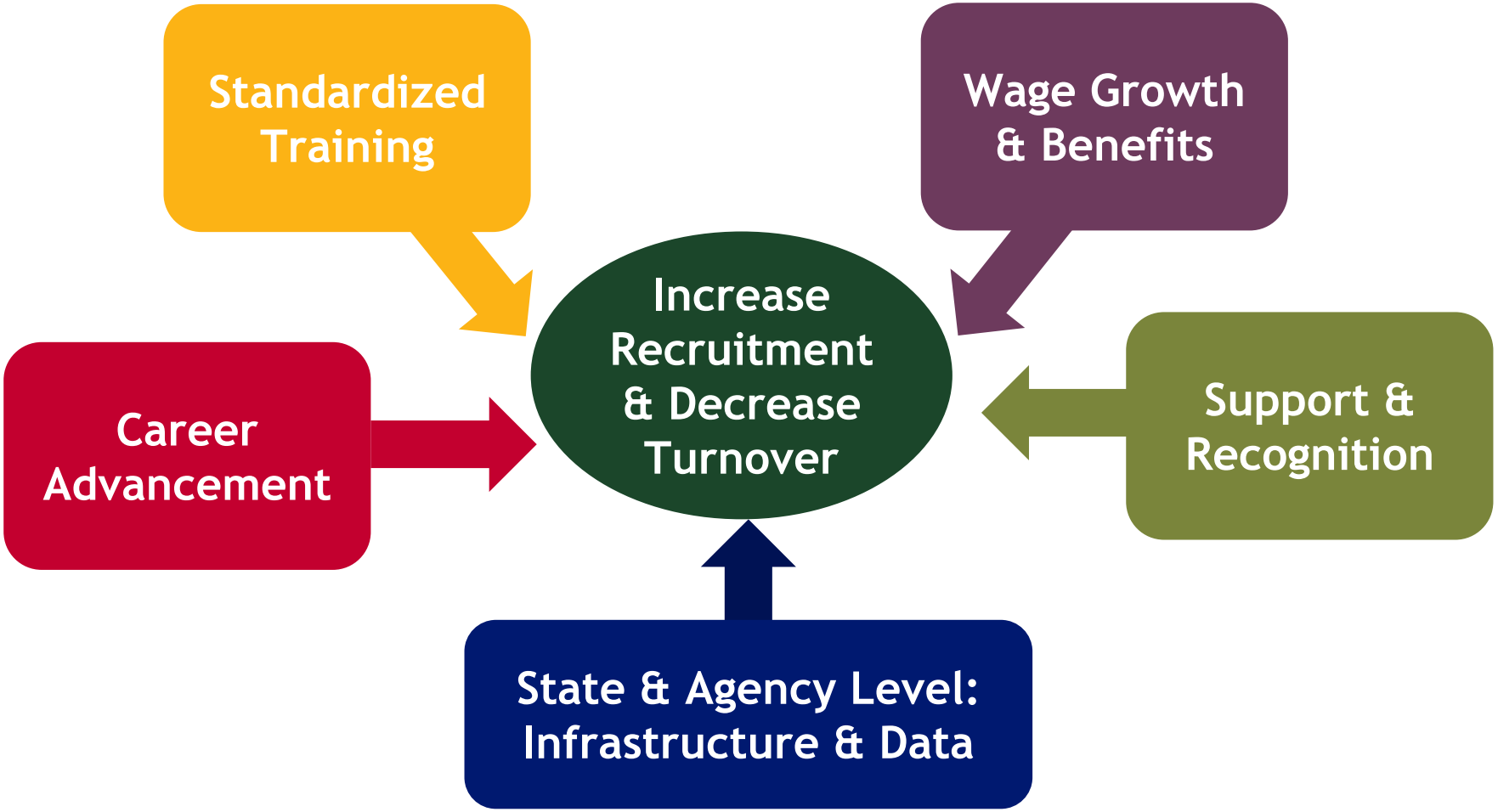
R-11
Questions 93-94

R-11 Request Overview



Direct Care Workforce Strategies

Strategies Employed by the Unit to Address the Direct Care Workforce Crisis



Stakeholder Voices

01	People Engaged	Advocacy organizations, workers, worker organizations, providers, members/ representatives of members, & representatives of state departments
02	Outreach Meetings	Active outreach through multiple strategies; engaged in nearly 100 meetings with other agencies/entities to identify areas of intersection, ways to align, & partner
03	Committee Participation	Represented on the four state-agency health care workforce committees to coordinate efforts & reduce siloed work; organized & hosted ongoing stakeholder committees
04	Regular Engagement	Routine engagement with key partners to ensure relationship building & partnership

Developmental Disabilities (DD) Waitlist Question 95-99

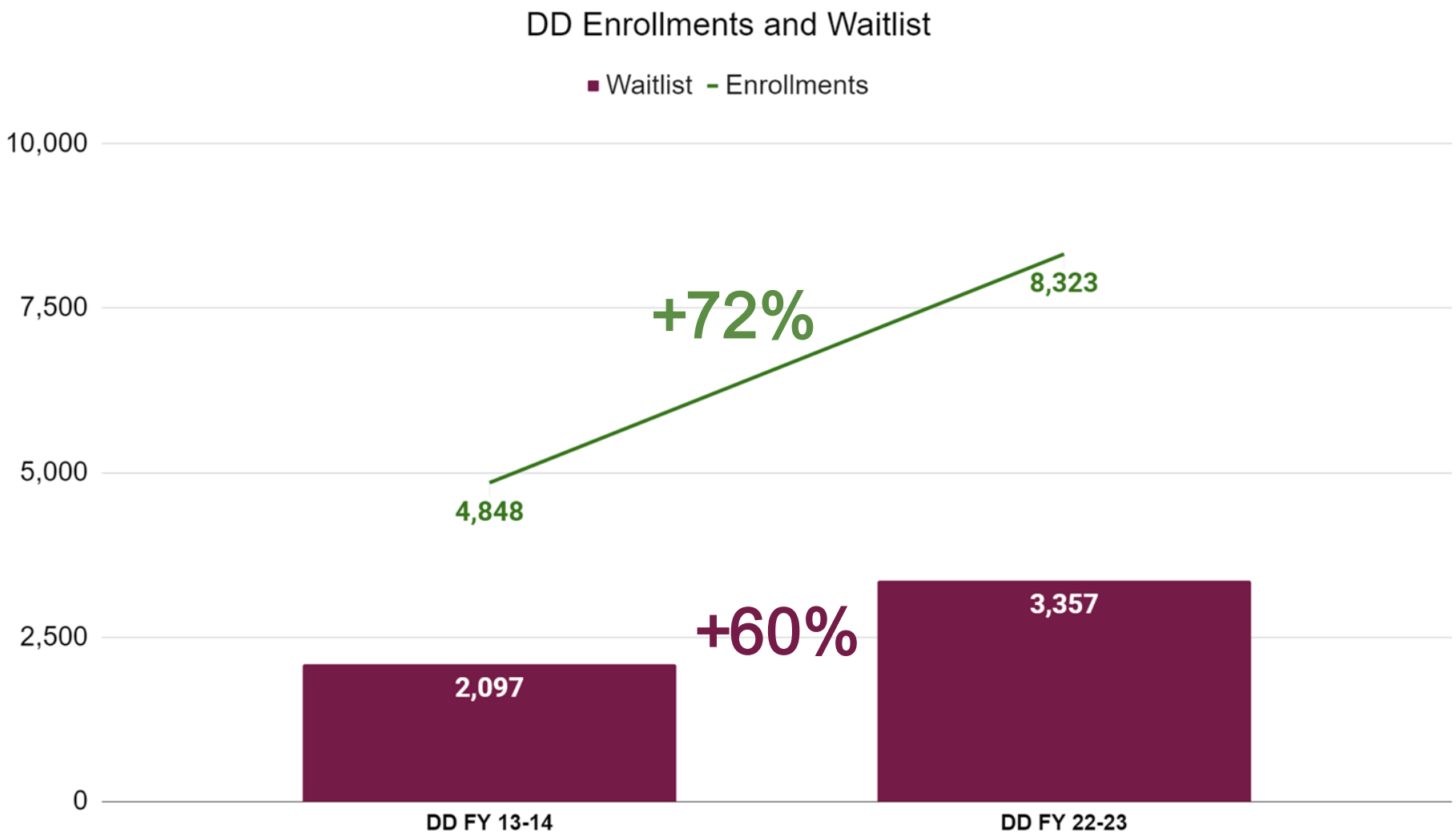
Managing the Waitlist

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

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

- New enrollments authorized through legislation
- Efficient management of the churn
- Reserve capacity enrollments

Waiting List Progress



DD = Developmental Disability Waiver

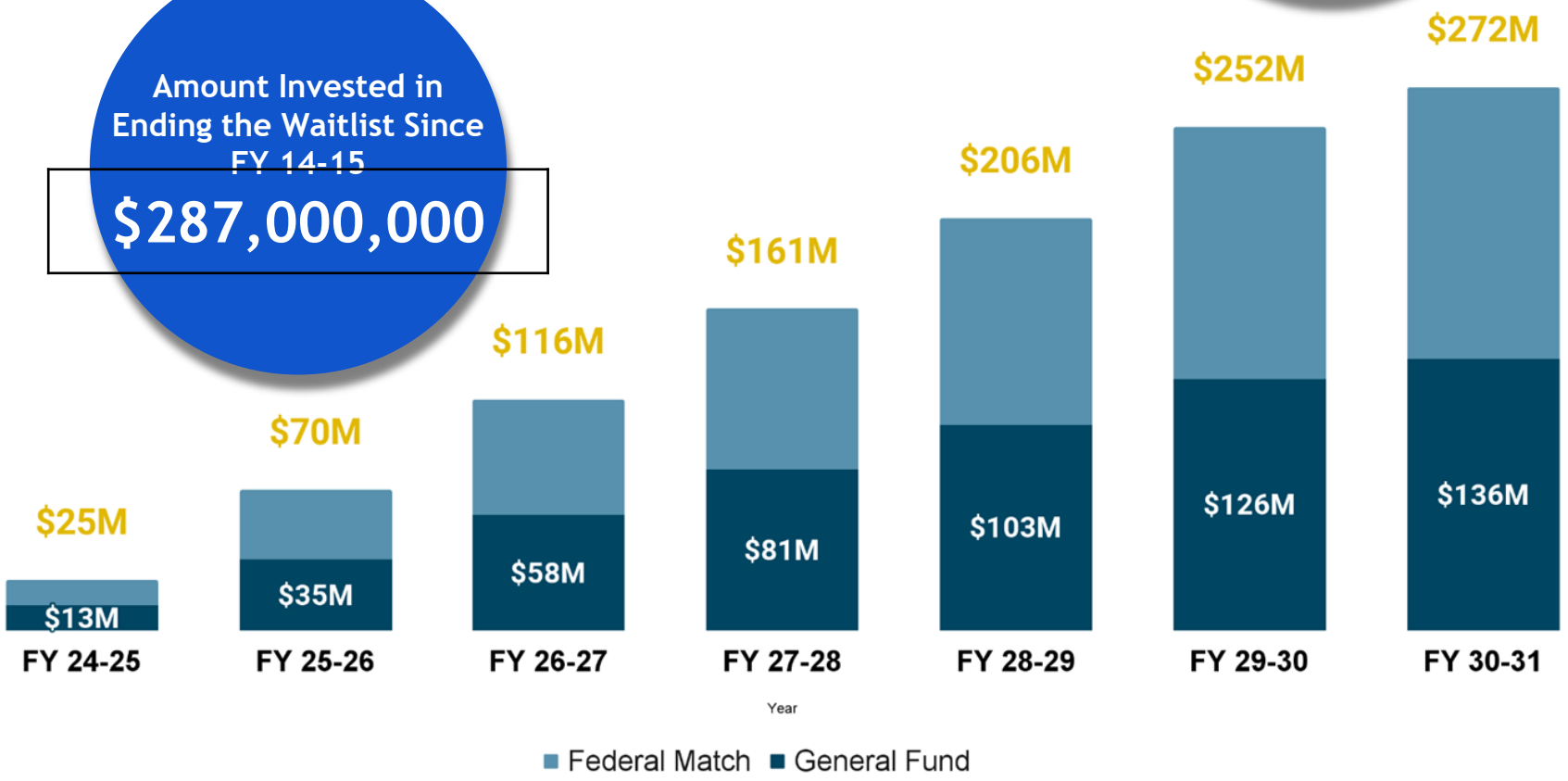
Investment for Enrollment Growth

Total cost to end the waitlist by 2031 & ~~ongoing~~

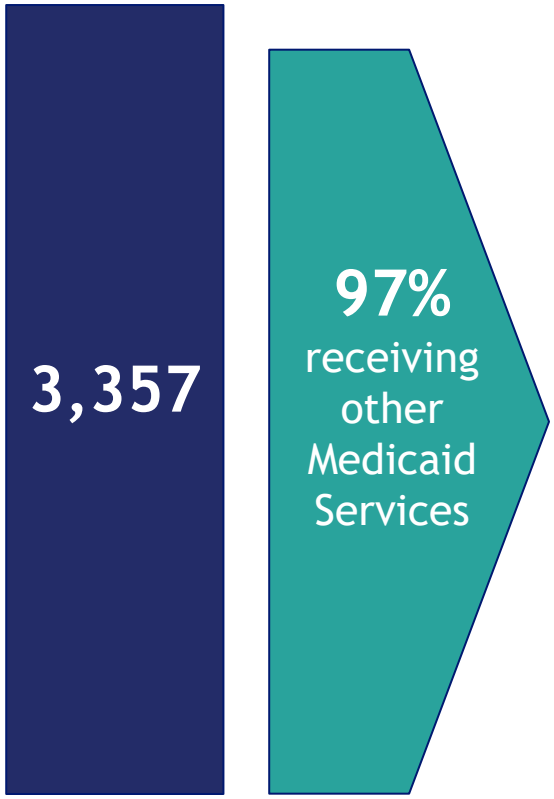
$272,000,000

Amount Invested in Ending the Waitlist Since ~~FY 14-15~~

$287,000,000

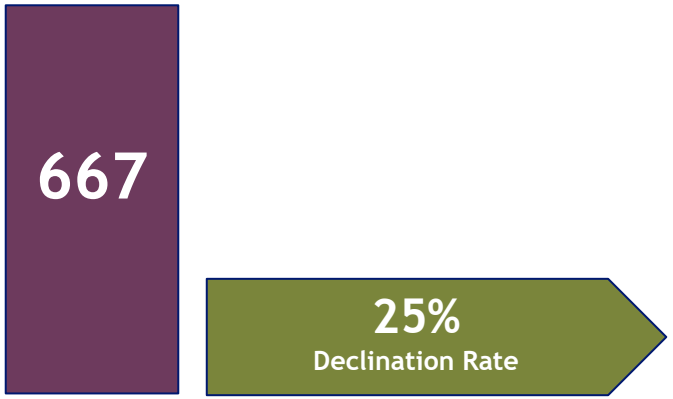


Meeting The Needs of Members



"As Soon As Available" DD Waiting List

Primary Declination Reason: Individuals reporting they are happy with their current services



New Enrollments Authorized through SB21-205

Care & Case Management System Questions 100-102

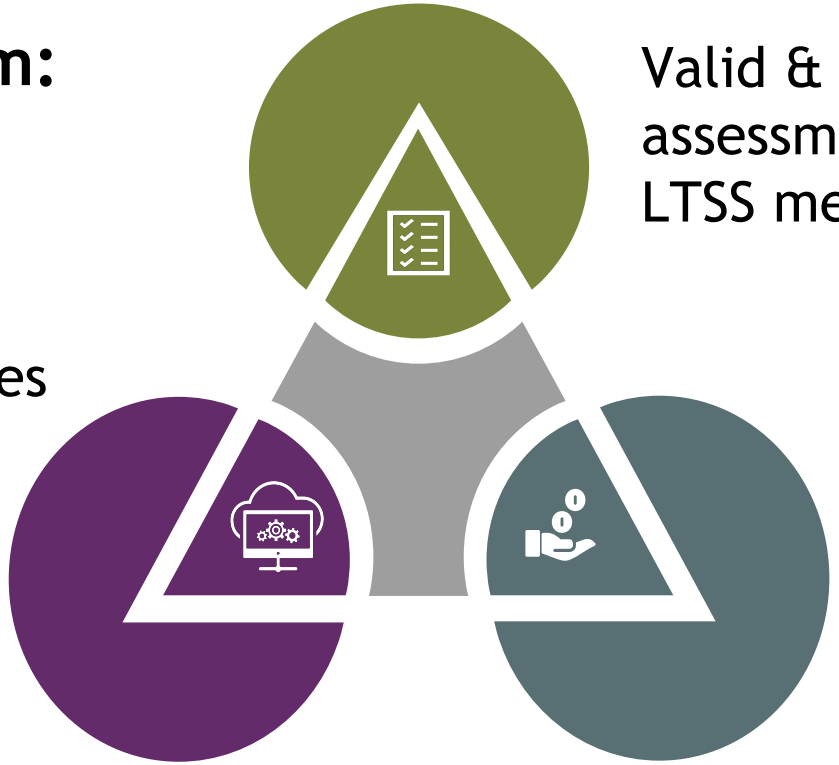
Care & Case Management System

Single Assessment Tool

Valid & reliable assessment for all LTSS members

New IT System: Care & Case Management

Supports interdependencies to streamline case manager & member experience



Person-Centered Budget Algorithm

Individualized budget range for members based on assessed needs

Thank You