Health Cabinet Policy Summit

March 24, 3-4:50 and March 31, 3-4:50

Summit recordings and materials are posted on our affordability website at
https://hcpf.colorado.gov/affordability

Below are questions and answers from the summit:

March 24, 3-4:50

Health Care Affordability for Coloradans

Question: Reinsurance: Are the premium savings cumulative? (20% year 1 and then additional 20% year 2)?
Answer: Each year when the Division of Insurance announces the Reinsurance Program premium savings, it is particular to that year (2020: 20.2%; 2021: 20.8%; and 2022: 24.1%). That means that the savings are a comparison of what the premiums would be in that given year *absent the Reinsurance Program*. Year 1, 2020, the savings were 20.2% on average statewide (up to 35% in mountain areas) over what premiums would have been without the program. And while the premiums savings are not cumulative, we have retained those savings for Coloradans going forward each year, so if the reinsurance program went away, then premiums would increase in the individual market on average about 20% - in the mountain areas, out east, in the Grand Junction area out west it could be up to 35%.

Question: With regards to reinsurance premium reductions, are you speaking of Private Insurance, ACA, Medicaid, CHP premiums?
Answer: The reinsurance program is focused on savings in the individual market. The pass through funding - the tax credits - are just for the individual market (the individual market is private insurance and what many people think of when they talk of the ACA - although the ACA is more than the individual market). When we reduce premiums in the individual market, we can capture those tax credit savings that pay for about two-thirds to three-quarters of the programs each year, a huge amount of money we get from the federal government. The Reinsurance Program is not part of Medicaid or CHP.

Question: Colorado Option: Access to care is encumbered by network confusion. Is there a way to remove the networks to reduce confusion and increase access?
Answer: Getting rid of networks completely would make it harder for health care plans to get to value in our system. We need to make sure networks are broad enough to serve all Coloradans and address equity. Increasing health equity is a critical component of the

Colorado Option and is specifically required in law. The Division of Insurance will continue to evaluate the adequacy of Colorado Option Networks using regulations that make sense for consumers.

Question: Colorado Option: Is the inflationary premium increase coinciding with inflationary provider reimbursement or based on something else?
Answer: The law sets forth that the premiums can only increase by national medical inflation every year of the Colorado Option. This requirement will help to keep premiums low even after premiums have been reduced by 15% in the first 3 years of the program.

Question: Should the waiver to enable the Colorado Option be authorized by the federal government, will there be new jobs available in policy analysis, system implementation, etc. to be filled? How will that implementation process work?
Answer: The Colorado Option law (HB21-1232) provides funding for the Division of Insurance to implement the Colorado option program. The Division is in the process of hiring new staff and working with contractors to meet the statutory requirements.

Question: If you can see the hospital $ price disparity but the network you belong to prohibits use of that less expensive hospital, how can you proceed to secure less expensive but out of network care?
Answer: Consumers should use tools provided by their health plan to shop for in network care that maximizes health care value, whenever possible. Consumers should make sure they are comparing providers that are in network with their plan, because seeking care out of network may lead to a large out of pocket cost for the consumer.

Question: Will trade associations be able to pool risk and negotiate with health plans in the future?
Answer: Health Care Coverage Cooperatives, also known as Purchasing Alliances, allow different health care purchasers (i.e., Individuals, Small Businesses, Large Businesses, and Self funded businesses) to work together to directly negotiate with health care providers to create lower cost health insurance products. Peak Health Alliance and the Southwest Health Alliance have been very successful in lowering premiums for their members using this model.

Question: Speak more about what insurance options might be available to the undocumented in 2023. Would they be subsidized at all?
Answer: Beginning in 2023, undocumented individuals will be able to purchase Colorado Option Plans through the exchange's Public Benefit corporation, known as Colorado Connect. For individuals who are low income, plans will be available for $0 premiums and little cost sharing. These plans will be subsidized using state funding as well as with federal pass through savings from the Colorado Option 1332 waiver.

Question: Is there any focus on lowering deductibles? I have seen at least five individuals that have avoided serious surgeries because they can't afford the deductible.
Answer: Minimizing consumer cost sharing is an important goal of the Colorado Option. Many high value services are provided pre deductible and with $0 copays (e.g., primary care and behavioral health visits). While federal rules constrain how much deductibles can be decreased, in designing the standard plan, the Division has worked to strike a balance between premiums, deductibles and other out of pocket consumer cost sharing.

Question: It looks like the expectation is for employers to be experts in health care expenses. So if you are a small business instead of selling the item you love, let's say books, you are managing healthcare expenses.
Answer: Colorado Option Plans help to take some of the complexity out of providing health insurance for your employees. Colorado Option are high value plans that are required to be offered at a lower cost. Small businesses can compare Colorado Option Plans from different insurance companies based on price and network, knowing that each plan provides the same coverage and benefits.

Question: Value Based Payment Arrangements tend to be very complex. How does the State intend to adjudicate the two Novartis Contracts?
Answer: The Novartis contracts use retrospective review of performance where we get additional rebates for performance that was substandard to the contractual requirements. Further details can be found in our press release:
https://hcpf.colorado.gov/colorado-medicaid-executes-its-first-pharmaceutical-value-based-contracts

Question: What entity will HCPF be using to evaluate the two new pharmacy value based initiatives effectiveness?
Answer: We are partnering with the CU Skaggs School of Pharmacy to provide data aggregation services.

Question: In my previous life, drug companies would offer providers rebates if volumes were met. I know we turned them down and requested lower prices, this was an uphill battle to just get less expensive supplies/drugs. Is there a way to collaborate with the state on this issue?
Answer: Yes! You can find out more about the Colorado Prescription Drug Affordability Review Board & Advisory Council at
https://doi.colorado.gov/insurance-products/health-insurance/prescription-drug-affordability-review-board

Question: Is there a homepage/gateway to help consumers navigate this information? How do consumers know what they should expect to pay for their medical needs? Thinking of a one-stop shopper's tool such as what CIVHC has created and updated? Call it a portal?
Answer: Some of the carriers have digital tools or smart phone applications that help you see the procedure and your out-of-pocket based on where you go. Others may just show cost and quality indicators. Some of the tools we are trying work to get you there, but the industry ranges from being ahead to others lagging behind. We've tried some solutions like provider directories and member education.

Question: I manage partnerships for a pharmacy and I'm very interested in our role to help with these initiatives. How can pharmacies get involved in these initiatives in lowering overall medication costs?
Answer: First, if your pharmacy isn't already in our Medicaid network, please enroll today at: https://hcpf.colorado.gov/provider-enrollment. Second, you can partner with the state on the Colorado Prescription Drug Affordability Review Board & Advisory Council.

Question: Is the provider tool available to pharmacists as well? Or how can pharmacists learn/understand this tool? To facilitate physicians use? In a clinic or hospital settings?
Answer: The tool is intended to be used by anyone writing prescriptions in outpatient settings. The Department is establishing education and training documents which can be used by pharmacists to understand the tool. For more information, please visit our website: https://hcpf.colorado.gov/prescriber-tool-project

Question: Regarding the prescriber tool, will there be safeguards in place to prevent incentivizing prescribing cheaper but less effective or less safe medications?
Answer: The Prescriber Tool empowers doctors and other providers prescribing medications with real-time information on prescription drug costs and affordable alternatives. The tool offers affordable alternative medications that may be effective to treat the patient's diagnosis. The provider is empowered with options and information but is still the ultimate decision-maker. Regardless of what the prescriber decides, the workflow is easier for the prescriber and delivers a better service experience for the member. In its initial phase, value-based payments and reporting would be based on using the tool to view the information; initial VBPs are not based on what medication is selected or its cost. For more information, please visit our website: https://hcpf.colorado.gov/prescriber-tool-project

Question: What is the plan for Colorado Indigent Care Program (CICP)?
Answer: The Department is working with the Colorado Indigent Care Program (CICP) Stakeholder Advisory Council on recommendations on the future of CICP website. The rules for the program are being updated to align as closely as possible with the rules for Hospital

Discounted Care, as created by House Bill (HB) 21-1198, to reduce administrative burden for CICP hospitals.

Question: Will hospitals with less than 25 beds get scrutiny in the future? I live in Chaffee Co where the chargemaster rates are 3-4 times other areas.
Answer: Yes, rural hospital analysis will be published in the future. The Department is currently working on projects to examine rural hospitals (including hospitals with 25 or fewer beds) with similar price, profit and cost metrics as in the Hospital Insights Report and other reports.

Question: I am a little confused about this in the Medicaid or Medicare environment - why does it matter which provider a PCP refers their patient to? Don't all providers in the state get paid the same so then best care provider for that specific disease?
Answer: No, all providers are not paid the same. Some commercial insurers already help patients receive the highest quality care at the appropriate site. We want to build off the success of commercial insurers and empower primary care providers in the Medicaid network with information about patient outcomes (quality) and affordability when they are choosing where to make referrals with the goal of our members receiving the highest quality care possible.

Question: Why is Colorado in the top ten on those four indicators? How did we get here?
Answer: As described in the Cost Shift Report, payments to hospitals rose and hospital profits grew, without a corresponding drop in prices. The Hospital Cost Price and Profit Review finds that hospitals are in a cycle of using profits to invest in market share growth initiatives, which further increases costs as well as the unfavorable impact of higher prices and larger profits.

Question: Super exciting about CMS. Will that partnership help improve scope for mental health providers? (for example, right now LCSWs and doctors are only able to accept Medicare. Need LPCs, LMFT, etc.)
Answer: At this time, we are only in the beginning stages, so this is TBD. However, this is a priority for the state as part of the state transformation collaborative.

Question: Is there someplace we can find a primer on "value-based payments for the layperson?" It's a pretty heavily jargoned topic and hard for the general public to wrap our heads around.
Answer: Value-based payments move from paying providers for the volume of care they provide to paying providers for the value that their care creates – measured by better patient outcomes and improvements in health equity. With that in mind, the federal Centers for Medicare and Medicaid Services (CMS) established goals for states intended to drive an increasing percentage of Medicaid payments into alternative payment models (or "APMs"),

like value-based payments, and away from fee-for-service payments. This quest to move from paying providers for volume to paying providers for value or outcomes is not new - it has continued across three White House Administrations. In Colorado, the Hospital Transformation Program (HTP) is a value-based payment program. The goal of the Hospital Transformation Program is to improve the quality of hospital care provided to Health First Colorado (Colorado Medicaid) members by tying provider fee funded hospital payments to quality-based initiatives (also known as Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) fees). Over the course of the five-year HTP effort, payments will reward improved quality, meaningful community engagement and better patient health outcomes. See https://hcpf.colorado.gov/colorado-hospital-transformation-program for more information. To read more about value-based payments within the context of Medicaid, consider: https://www.macpac.gov/subtopic/value-based-purchasing

Question: Are you seeing the CO not-for-profit large health systems provide more charity care compared to national averages?
Answer: No, we do not see Colorado not-for-profits providing more charity care than the national norms. In 2018, Colorado not-for-profit charity care costs as a percentage of net patient revenue are 1.4%, which is less than the national median of 1.8%. Independent hospitals and some hospital systems (Banner Health and Centura Health CHI) have higher charity care cost as a percent of net patient revenue than the national median. The remaining hospital systems have a lower charity care cost compared to the national median. For more information see page 42 of the Hospital Cost Price and Profit Review available on the Hospital Reports Hub at https://hcpf.colorado.gov/hospital-reports-hub.

Question: If time permits, I would like to ask the HCPF Experts about this: I am working with a SSI beneficiary who has LTC/DD, but wants to work full time. His employer would like to pay him $20/hr. x 40 hours/week, which will put his income over the LTC income limit. We know the WAwD program won't work with the DD waiver until 2023. Why won't Health First CO allow him to utilize 1619b Medicaid in conjunction with LTC, allowing him to earn up to the 1619b income limit, which is much higher?
Answer: An individual who is eligible for SSI, even under 1619B status, can be eligible for Long Term Care 300% Medicaid under the Home Community Based Services waivers as long as they have a current level of care assessment. No application is needed but they do need to contact their eligibility site that their circumstances have changed to need services in order to start the referral process with the case management agency. If they have a case management agency and have already been assessed to meet level of care, this information needs to be sent to the eligibility site. We have this in our rules at 8.100.7.B.1

8.100.7.B. Persons Requesting Long-term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

a. are SSI (including 1619b) or OAP Medicaid eligible; or

b. are eligible under the Institutionalized 300% Special Income category described at
8.100.7.A; or

c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities
described at 8.100.6.P. For this group, access to HCBS:

i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health
Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported
Living Services (SLS) waivers; and

ii) Is contingent on the Department receiving all necessary federal approval for the
waiver amendments that extend access to HCBS to the Working Adults with
Disabilities population described at 8.100.6.P

Behavioral Health Transformation

Question: Can you please expand the opportunities for Medicaid recipients to receive detox more than one time every 30 days? We are seeing so many individuals who are willing, courageous and ready for treatment who go through medicaid funded detox … these individuals then attempt to get into treatment without any beds available! Then when there are beds available, these individuals are required to go back through Medicaid funded detox which is required prior to intake but they cannot do this due to your rule of only one detox every 30 days. Can you please update this archaic rule that doesn't work in actuality or reality?
Answer: Medicaid does not have a rule limiting detox to once every 30 days. Medicaid does not require an individual to go through detox prior to intake for residential or inpatient treatment.

Question: Any activity or movement to fund Community Integrated Health Services using Community Paramedics, Treatment in Place/Treat and Release for EMT and NEMT services, and funding for mobile crisis response units? Very impressive numbers. I hope it really improves availability and accessibility and affordability of behavioral health.
Answer: The Department has continued the work that led to the formation of Community Integrated Health Care Service (CIHCS) licensure through multiple efforts. The Community Paramedic provider network was engaged through work with the Medicare payment model (the Emergency Triage Treat and Transport or "ET3" program) with Colorado Medicaid participation in all planning and state-wide alignment meetings. The Secure Transport benefit (based on Colorado legislation to allow Behavioral Health transport to appropriate locations besides Emergency Departments) is currently in development and will be implemented in 2023. Utilizing a planning grant through the American Rescue Plan Act (ARPA), the Department is assessing Behavioral Health Mobile Crisis Response in Colorado and intends to develop a benefit that strengthens and expands the current efforts across the state. In recognition of the intersections of these initiatives, the Department has created a Wraparound Unit within the Special Projects section of the Population Health Division in the Health Programs Office to assure alignment and assure continued activity in this space.

Question: Can you please share the distinction between OBH and the BHA?
Answer: Starting on July 1, 2022, the Office of Behavioral Health will consist of the Mental Health Institutes (MHIs) at Pueblo and Fort Logan as well as Forensic Services. We anticipate that this name will change to better reflect the scope of the MHIs and Forensic Services teams. The Community Behavioral Health programs (the other part of the current OBH) will move into the Behavioral Health Administration (BHA). These are the statewide services that are funded through SAMHSA block grants, general funds and other initiatives aimed at

community behavioral health statewide services, indigent or under-insured services, and programs aimed at capacity expansion and innovation. These programs will be integrated into the other functions of the BHA.

Question: Can HCPF point us to research supporting the efficacy of medical and behavioral health professionals referring out to non-clinical community supports (such as the peer supports mentioned)?
Answer: Community health workers and peer support programs are so important for recovery, which is where people spend most of their time when they move on from needing acute level services. We know these help keep people safe and keep people well. House Bill 1281 would set up the community behavioral health-care continuum gap grant with $90 million. The grant program would be available to local governments, community-based organizations and nonprofits for "programs and services along the behavioral health-care continuum" for children, youth and family-oriented behavioral healthcare. This bill would help support these workers and put patients first. Some research you may consider include:
https://mental.jmir.org/2020/6/e15572;
https://link.springer.com/article/10.1007/s11606-016-3922-9;
https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-040119-094247; or
https://mental.jmir.org/2020/4/e16460.

Question: Are there efforts within the behavioral health system to cohesively collaborate with entities with aligned priorities like public health, education, primary care, etc?
Answer: Absolutely. That's one reason Behavioral Health Administration (BHA) Commissioner Medlock is doing the tour. We are looking for creative partnerships to solve the problems in our system.

Question: How does an agency connect with you to participate in this tour?
Answer: Please reach out to Equity & Community Engagement Director René Gonzalez at rene.gonzalez@state.co.us. You may also visit the statewide tour website at cdhs.colorado.gov/bha-statewide-tour

Question: We are finishing up a pilot study on integrated primary care and have found that the IT departments in health systems are a huge barrier to successfully rolling out this approach. What strategies are you building into this plan to encourage IT departments to be willing to pilot these efforts?
Answer: HB 22-1302 which passed this session, provides grant funding for integrated primary care practices. The funding is allowed to be used to address IT systems including electronic health record systems (EHRs). The state continues to inform our federal partners about the significant barriers regarding the regulations for substance use disorder data and how it negatively impacts patient care.

Question: When will the application process begin for the co-chaired position by someone with lived experience?
Answer: The application process begins one week after the passage of the BHA bill, HB 22-1278. Applications are already out.

Question: What is the administrative and program cost of implementing the BHA, HB 22-1278?
Answer: The published fiscal note can be found here. Updated versions of the HB 22-1278 Fiscal Impact may be contained on the HB 22-1278 page on the Colorado General Assembly website: https://leg.colorado.gov/bills/hb22-1278

Question: How will the State address services to individuals with intellectual and developmental disabilities and comorbid mental health concerns?
Answer: The State has committed American Rescue Plan Act (ARPA) funding and resources to providing training to practitioners to help them feel more prepared to serve individuals with co-occurring behavioral health and intellectual and developmental disabilities. The State is also considering the specialized needs of people with intellectual and developmental disabilities as we look to resolve gaps in the continuum of care.

Question: How does the behavioral health administrative services organization (BHASO) align with the existing RAE - BH structure and service delivery system?
Answer: The regions for the BHASOs will be aligned with the RAEs and the agencies are expected to work closely together. The BHASOs and RAEs will have a number of shared responsibilities like data reporting, building behavioral health networks, and coordinating care for clients and with providers. The BHASOs will focus on BHA funding that supports uninsured Coloradans and supports system capacity. The RAEs will continue to administer the state's behavioral health Medicaid benefit, serving Health First Colorado members.

Question: What are some examples of programs that will remain in their "home agency" (as noted under the agency agreements Dr. Medlock mentioned)?
Answer: Examples include programs in Colorado Department of Education that are tailored to partnership with school districts on increasing resilience in youth or housing voucher programs in Department of Local Affairs that are for populations with behavioral health conditions but the program itself is focused on housing and requires nuanced expertise in housing. The BHA will work in close partnership with these agencies to ensure a shared strategy and approach and can become a resource and advocate for the programming.

Question: How will BHA and HCPF hold the state's CMHCs accountable for providing timely services to meet community needs?

Answer: We are working to increase oversight in four areas: (1) new cost reports to calculate new reimbursement rates to be used in the capitated rate models; (2) a universal contract that would connect payments to safety net services; (3) value-based payments; and (4) reducing administrative burden to CMHCs while increasing meaningful accountability to outcomes. The BHA with HCPF and other agencies will also be working to enhance standards for licensure with tiered accountability measures through the implementation of the safety net (as part of the implementation of our Plan to Expand and Strengthen the Behavioral Health Safety Net, in alignment with Colorado State Senate Bill 19-222, which includes expanding the behavioral health provider network).

Question: How will you address the bureaucracy/reimbursement issues that discourages providers from taking Medicaid?
Answer: The universal contract is designed to be a new payer-provider contracting tool to establish expectations across CMHC providers, including driving accountability for key deliverables such as treating the most complex patients, meeting community needs and other essential stakeholder interests. The universal contract for safety net providers will help make sure that the new Behavioral Health Administration, HCPF and CDHS (as well as other state agencies) are able to hold providers accountable to the same standards and expectations while also providing more consistency from a payer perspective. Work teams to create and negotiate these universal contracts are already established.

Question: Where are the new 64 beds that Michelle mentioned? CO needs more structured housing for SMI patients.
Answer: The 64 beds will be at the Colorado Mental Health Institute at Fort Logan (in Denver), but we are working on increasing beds across the state.

Question: The new older Americans update bill has a section of a "high level" master committee for the departments that are key to senior needs. What is the status of this committee?
Answer: This refers to the Advisory Committee to the Office of Adult Aging and Disability Services and the Division of Aging and Adult Services. Following the recent signing of the bill, we will be working with our peer agencies to pull this advisory committee together (this would include staff from HCPF, CDPHE, DOR, CDLE, and transportation) to assist us in identifying needs of the aging community.

Question: The co-responder programs are so amazing. One of the biggest barriers in rural communities is cost for the program compared to numbers served. How will this plan support rural communities with co-responder program? Can you point me to that information?
Answer: HB 22-1214 Behavioral Health Crisis Response System makes it clear that individuals experiencing disabilities must be served. It's not data but IT departments.

Question: When rate setting for behavioral health care providers, are these rates aligned with a national compensation model? I'm curious to know how the patient voice and experience was incorporated into both behavioral health policy and physical health?
Answer: Several issues affect rate setting for behavioral health providers, including federal antitrust laws and the use of a managed care system for behavioral health care services in Colorado. Federal antitrust laws are complicated; however, in general, it is important to recognize that behavioral health providers are the sellers of services. If RAEs publicly release fee schedules, in theory that information would give the sellers of services the ability to artificially inflate rates or allow other payers to collectively depress rates. Both would be violations of the law. From a policy perspective, we want high quality, affordable services that benefit Health First Colorado (Colorado's Medicaid program) members. Sharing rate information would make that goal less achievable. Under a managed care system, the managed care entity receives broad parameters for its operation. The Department contractually requires that the Managed Care Entity (MCE) meet certain network adequacy standards and that the MCE pay for services within the range of an actuarially sound risk corridor. Those actuarially sound rates are set based on historic utilization, national benchmarks and trends, and public policy adjustments. It's up to the MCE to figure out how to contract within those parameters and if they don't the MCE is at risk. The MCE could be forced to pay back money or could even lose the contract.

Question: Could you outline some of the accountability metrics that will be used to ensure equitable outcomes? What do the community-based partnerships look like?
Answer: Some of the accountability metrics to ensure equitable outcomes include:

- **Ensure equitable outcomes:**
  Accountability metrics will ensure equitable outcomes by monitoring effectiveness by sub-population with a focus on those with existing disparities. Additionally, it is critical that standards are improved in demographic data collection to reduce disparities as a result of under-representation in key accountability metrics. Specific measures may include access to care, quality of service and satisfaction at an individual level. The specific measures remain under development and will be tied to standards as well as payment for providers.
- **Community Partnerships:**
  The BHA has new and dedicated positions working to ensure there is collaboration with local and county government and community stakeholders. Community based partnerships will take on many forms, however all will be grounded in the key goals of bringing regional voices to the state through active engagement (through the Advisory Council and BHA resources targeted at cross-sector partnership). Additionally, the BHA can serve as a convener to bring key partners together within a community to address specific concerns, patterns and support a cross-section solution.

Question: Are we addressing the "affordability" of obtaining a medical or mental health education?
Answer: The Department of Health Care Policy & Financing (HCPF) recently participated in a grant program to increase the workforce through providing free online training and skill enhancing services to persons working in non-medical home care services, personal care, homemaker and In-Home Support Services to the elderly and disabled Medicaid community. HCPF had successful outcomes for the 66 participants demonstrating increased skill and efficiency, increased employee morale, and increased learning retention from training. Since this small pilot (six months) proved so successful, we are looking to replicate it and increase the reach of the model through American Rescue Plan Act funding.

March 31, 3-4:50

Hospital Insights Report Findings

Question: How does the amount of hospital community benefit compare to the value of the hospital's tax exemption?
Answer: The Department has done a high level analysis on the value of a hospital's tax exemption and these estimates are within the Hospital Community Benefit and Accountability Report. Unfortunately, there are challenges with understanding a hospital's true community benefit to make these comparisons. The data shows what hospitals expended on community benefit activities, but doesn't show if these community investments are actually benefiting the community and that there is a return coming back into the community from what the hospital invests. Another thing to keep in mind, profits from tax-exempt hospitals are after they have made community investments and have covered underpayments from Medicaid and Medicare.

Question: Why are you ignoring the HB19-1176 taskforce report, which showed single payer covers everyone, saves billions and assuages social issues as compared to what we have now and a public option system? It is a win-win-win solution. It was a bipartisan bill that showed the way forward. It is completely in your purview--state initiated bill and report.
Answer: We are not ignoring HB19-1176. The Colorado School of Public Health issued a report that showed a single payer model would bring value to the system. However, the comparison was missing some very big factors; for example, Medicaid today has minimal co-pays to enable access to health care for low-income Coloradans; the model of the report didn't take that account and would've increased those co-pays. More nuanced and detailed research will better enable future policy considerations. The report findings were also presented to the Joint Committees before HCPF's SMART Act hearing, which gives the Legislature an opportunity to consider next steps as well.
Question: There seems to be a lot of focus on hospital transparency, but what accountability is placed on payers?
Answer: Colorado House Bill 22-1285 Prohibit Collection Hospital Not Disclosing Prices would include opportunities for both hospitals and carriers to use the information to consider price reductions. Additionally, the bill allows the Colorado Department of Public Health & Environment (CDPHE) to consider whether the hospital is or has been in compliance with federal hospital price transparency laws during the license renewal process. Under related federal regulations for insurance carriers price transparency, beginning July 2022 most group health plans and issuers of group or individual health insurance are required to disclose pricing information including in network rates for all covered items and services and allowed amount for out-of-network providers. This price information from carriers in addition to

hospital prices will bring transparency to consumers' health care prices and allow for analysis to inform policy decisions.

Question: I struggle to understand the emphasis on hospital prices? This was relevant when payor contracts were based on "percent of billed charges", but today few, if any, reimbursement methodologies are based on prices. Don't payors (Medicare, Medicaid, commercial) also have accountability for the rates they pay for hospital services?
Answer: THospital prices represent the largest component of health care costs and the second biggest driver of health care cost increases. The prices that are being examined are the ones being paid by carriers, which are financed by employer and consumer premiums. It is the actual contractual price, not charges from hospitals' chargemasters. Moreover, we have seen Colorado hospital prices paid by commercial carriers and borne by employers and consumers continue to increase even though Medicaid's reimbursement has improved and the number of uninsured Coloradans has decreased by half. The result is higher hospital profits and reserves.

Question: The corporatization of health care threatens the delivery of culturally responsive care which is critical to reducing health disparities.
Answer: All of us have to do our part in bringing more cultural competencies - hospitals, doctors and payers. In Colorado, the Hospital Transformation Program (HTP) is a value-based payment program with hospitals. The goal of the HTP is to improve the quality of hospital care provided to Health First Colorado (Colorado Medicaid) members by tying provider fee funded hospital payments to quality-based initiatives (also known as Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) fees). Over the course of the five-year HTP effort, payments will reward improved quality, meaningful community engagement and better patient health outcomes. This includes projects on health care disparities and reporting race, ethnicity and language data so that we can identify and address health disparities. See https://hcpf.colorado.gov/colorado-hospital-transformation-program for more information.

Question: Given UC Health receives considerable funding as a public educational institution and is a quasi state entity, what pressure can be put on them to use their reserves for community benefit? The level of profit being earned by these hospital systems, but especially UC Health, are shameful and seem almost criminal.
Answer: The **Hospital Insights Report** found that the hospitals in the UCHealth system reported 10.1% total profits in 2020 and the larger health system reported 17.4% total profits from January through September 2021. The **Hospital Insights Report** is on our Hospital Reports Hub website: https://hcpf.colorado.gov/hospital-reports-hub and includes policy considerations as well as potential next steps.

Question: Can you discuss how Colorado Medicaid reimburses more than the Medicare amount, despite the federal upper payment limit (UPL)? I've had colleagues from other states ask this and I've struggled to answer it.
Answer: The federal UPL requires that Colorado Medicaid cannot pay more than Medicare payment principles, but does not specify that Colorado Medicaid can only pay the Medicare rate. Through the Colorado hospital provider fee, the approved UPL is the cost of providing care to Medicaid recipients. When we look at the data, we see that Colorado Medicaid reimburses better than Medicare.

Question: What about members served annually for hospitals as a comparative?
Answer: Thank you for the feedback. Payer mix comparisons are included within the Department's Hospital Expenditure Report. We can consider providing more granular utilization information in future publications and reports, as available.

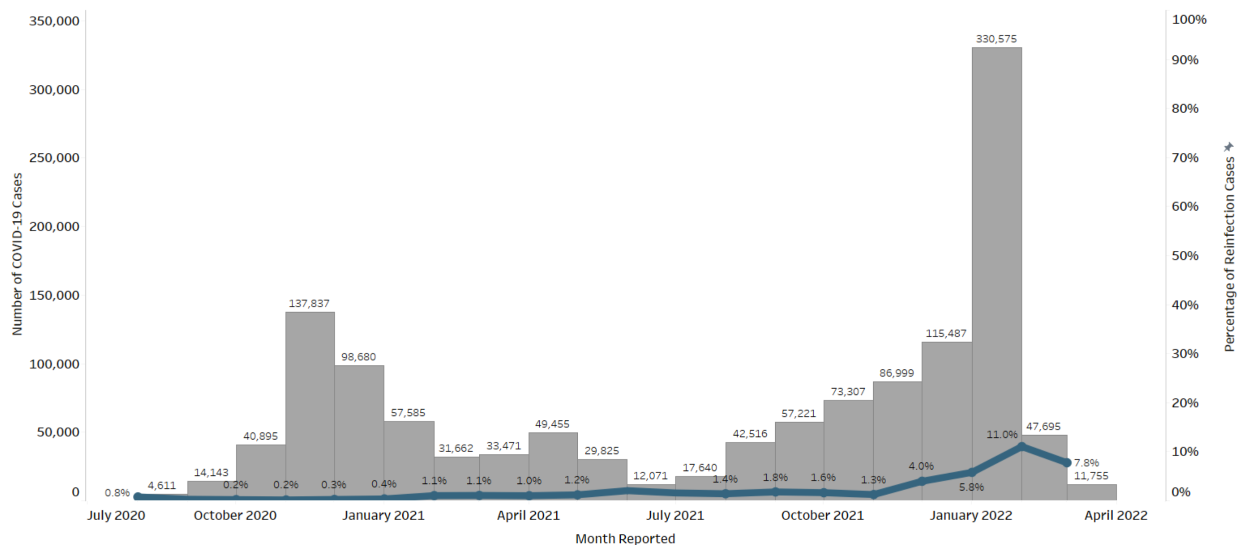
Question: If hospital costs in Colorado were at the national average, how much money would Coloradans save?
Answer: The Department estimated 2018 savings within the Hospital Cost Price and Profit Review that show that Coloradans would have saved $3.0 billion if hospital prices were at national median levels. More recent estimates show that Coloradans would have also saved $3.5 billion in 2019 and $3.0 billion in 2020. Had hospital prices been at national medians, Coloradans would have saved $9.6 billion between 2018 and 2020.

Question: HTP and other initiatives increasingly rely on health-related social and human services provided by community-based organizations. How are the Office of Saving People Money in Health Care, HCPF and DOI thinking of investing in these CBOs so that they have capacity to meet the increased demand?
Answer: In regard to the Hospital Transformation Program (HTP), the HTP is focused on work the hospitals can do to fill gaps between the acute care and ambulatory and community spaces to better help those other settings meet their missions and better serve the Coloradans they support and care for. The identified gaps and areas of opportunity were based on areas of need identified by these key stakeholder groups in the planning for HTP. We were particularly focused on the answers to the question of: "What could hospitals be doing better to help you achieve your mission?" From this information and within the confines of what the program could impact, the result has been important developments statewide in how hospitals transition care to the primary care and community setting through data sharing and notification processes, and how they ascertain, acknowledge, and address unmet social needs within the delivery system and communities that they serve. The HTP will provide valuable information as to best practices across the state, and its cornerstone of community engagement will provide important insight into the best opportunities for investment and areas of sustainability in the future and where the efforts of hospitals can be best aligned and

support community-based organizations and ambulatory care providers. This year, the Office of Saving People Money on Health Care requested funding from the legislature to support a Medical-Financial Partnership Pilot Program, a collaborative arrangement between health care providers and community-based organizations, that provides a variety of financial services aimed at improving financial security for patients and families. This request promotes equitable policy-making by targeting resources to improve well-being in populations disproportionately impacted by economic, social, and political inequities resulting in high concentrations of chronic disease. This public-private partnership approach will aim to leverage matching funds from health systems and other institutions to save people money on expensive or delayed care and create a sustainable MFP model in Colorado.

COVID-19 Pandemic to Endemic, Future Readiness

Question: What are the stats on reinfection and vaccinated infection?
Answer: Vaccines are the easiest way to slow the spread of COVID-19 and to prevent serious illness and hospitalization. Individuals who are up-to-date on their vaccinations are 10.4 times less likely to die from COVID-19 than individuals who are unvaccinated. Since no vaccine is 100% effective, and all authorized COVID-19 vaccines were developed when an earlier strain of the virus was globally predominant, cases among vaccinated individuals are expected. We track the breakthrough rate on our website by vaccine type and by certain demographics. The data team is also able to report on some reinfection data. Reinfection case data is incomplete and underreported due to individuals not being tested during their first or second infection, especially those with asymptomatic infections or mild symptoms. Therefore, individuals may not know they had COVID-19 prior to a new reinfection case. CDPHE started tracking reinfections in August 2020, and the proportion of reinfection cases among all cases reported hovered around 1% until the delta and omicron variants came into play in December 2021. The proportion is now around 8% and declining.



Question: What is CDPHE's response to folks who remain on the fence about getting the COVID vaccine?
Answer: We know that vaccines are safe and offer significant protection against serious illness and hospitalization. The vaccines are monitored intensely for any safety concerns, and more than 225 million people in the United States have now received a vaccine. Individuals

who are up to date on their vaccinations are 10.4 times less likely to die from COVID-19 than individuals who are unvaccinated. Coloradans can receive a vaccine at one of hundreds of convenient locations across the state. No insurance or ID is required to get vaccinated, and the vaccines are free. Under state law, Coloradans are entitled to paid time off from work to get vaccinated and recover from side effects. We are thrilled to have vaccinated more than 4.4 million Coloradans with at least one dose of the vaccine, and we encourage all eligible Coloradans to get vaccinated with all recommended doses. We also are working diligently to provide factual information about the safe and effective vaccines that are saving lives.

Question: In the test and treat model can you explain the mechanism for reporting. Will there be anticipated lag time of that data
Answer: President Biden recently announced the "Test to Treat" program that will allow individuals to get tested at pharmacies, and if they test positive, they will have immediate access to COVID-19 treatments. In addition, the president announced that Americans will be able to re-order four rapid at home tests. All individuals or entities performing COVID-19 testing of any kind are required to report results to CDPHE as required by Public Health Order 20-33 and Board of Health regulations. They can report through the CDPHE's electronic laboratory reporting platform or other secure, CDPHE-approved method. All COVID-19 test results should be submitted to the ELR within one day. Pharmacies, and all other entities who administer COVID-19 tests, must report results to the Colorado Department of Public Health and Environment.

Question: Can you share information on the impacts for Coloradans r/t to the closure of the COVID–19 Uninsured Program, operated by the Health Resources and Services Administration? Will uninsured community members be able to access services from primary care and pharmacy providers for testing, vaccine, treatment? From a state run vendor?
Answer: Colorado has urged Congress to secure funding to continue the HRSA COVID-19 Uninsured Program for testing, vaccines and treatments. We are deeply concerned about the sunsetting of the HRSA Uninsured Program on April 5 and are currently gauging the anticipated impacts to our enrolled COVID-19 vaccine provider networks. The discontinuation of the HRSA Uninsured Program will make it more expensive to provide life saving vaccines and treatments to uninsured Americans. Some providers may be able to absorb these additional costs, but many others will not. The state's mobile and pop-up vaccine clinics will continue operations through at least June 30 to help make sure the COVID-19 vaccine is accessible to all Coloradans. The vaccine will remain free to all at these clinics, regardless of insurance status. As CDC's vaccine recommendations evolve and expand, we remain ready to fill in any gaps and make sure any Coloradan who wants a vaccine can easily find one for free. In addition to mobile and pop-up vaccine clinics, there are numerous equity-focused, vaccine-related resources and programs that will continue as part of our strategies to address health disparities, including regional equity coordinators and resource specialists, the Champions for

Vaccine Equity program, a forthcoming equity-focused grant program, and CDPHE's partnership with 9Health:365 to offer free and low-cost vaccinations and health screenings. The COVID-19 vaccine is and will remain free for the foreseeable future. Coloradans do not need ID or insurance to get vaccinated. Under CDC's vaccine provider agreement, providers cannot charge patients for vaccines and cannot turn uninsured patients away. Coloradans can continue to access free testing at community testing sites, pharmacies, and rapid distribution centers across the state. Uninsured individuals are encouraged to apply for health coverage through Health First Colorado (Colorado's Medicaid program) as it will cover testing, vaccines and treatments for COVID-19. We encourage anyone who is turned away from a vaccine clinic due to their insurance status and/or charged directly for a COVID-19 vaccine to file a complaint with CDPHE through our online Vaccine Concerns form.

Keeping Coloradans Covered After the End of the Public Health Emergency

Question: Is there any indication as to when the public health emergency (PHE) may end?
Answer: We are readying ourselves for Jul. 15 - the current PHE expires Apr. 16, but we know that our federal partners will give us 60 days notice. We expect at least one more extension of the PHE.

Question: Within the normal year (not PHE), how many Coloradans enter Medicaid and how many exit Medicaid?
Answer: We work hard to provide health care coverage when Coloradans need us the most. Some folks are with us a short time, some longer, it is an honor to serve every single member. The precise numbers and percentages of people entering and exiting Medicaid in any given year fluctuate based on overall economic conditions. During a downturn, the number of people entering Medicaid increases and the number exiting decreases. The opposite is true when the economy improves, a higher percentage of the Medicaid population exits than the percentage that enters. Just before the PHE, the Department analyzed Medicaid eligibility patterns over a two year period. The analysis included each of the 1,763,857 people who had at least one day of eligibility between January 2018 and December 2019. The two years included in the study spanned a timeframe in which the economy was good and was steadily improving. Within that two-year period, 43% of the people were eligible for the entire span. Approximately 16% of the population (275,966) were not eligible on January 1, 2018, but gained eligibility at some point thereafter and retained eligibility through the end of 2019. A little over 20% of the population (376,674), were eligible on January 1, 2018, but exited Medicaid at some point during the following two years and did not regain eligibility. Another 20% (353,828) cycled on and off eligibility during the two years. Most people (95%) who cycled had only one gap in coverage during the two years. Slightly less than 5% of people had two gaps in coverage. Only 0.2% of people who had cycled between being eligible and not being eligible had three or more gaps in coverage. The pattern of people entering, exiting, and cycling between coverage status over the two-year period was fairly steady. It is therefore reasonable to *estimate* that about 8% of the total Medicaid population covered in those two years entered Medicaid, about 10% exited Medicaid, and about 10% cycled between being eligible and not being eligible in each of the years 2018 and 2019.

Question: Why did the state send out recovery letters to the affordable care act Medicaid folks and the Medicare Savings Folks - neither program is recoverable. We have had a significant number of calls on this letter in the last two days. Also Fox news aired a situation that the state wants to "recover" by taking a woman trailer and belongings for long term care for her husband. Is this the message Colorado wants in the communities to increase the divide and mistrust... So much for the goal of "all".

Answer: The estate recovery program overseen by the Department of Health Care Policy & Financing is a requirement that was imposed by Congress and signed into federal law. As such, states do not have discretion whether to make recoveries from estates of individuals who are either institutionalized or received long term care services at age fifty-five or older. The Department has a legal duty to notify Medicaid applicants and members regarding the terms of the program. We also believe as a matter of policy that it is in members' best interest to receive notice of the program in order to make informed decisions regarding their medical assistance benefits. Currently notice of the program is narrowed to members age 50 and over as well as members receiving long term care services. This ensures that this important information is received by individuals who likely may be impacted by the program at the time of notice or in the future.