COLORADO
Department of Health Care Policy & Financing

Responses to Advance SMART Act Hearing Questions

January 22, 2025

Medicaid Unwind

1. **National experts have been extremely critical of Colorado's efforts to mitigate the damage due to the unwind. According to the presentation HCPF gave to the JBC on June 20, 2024, during the medicaid unwind, a third of all initially disenrolled members returned to Medicaid and CHP+. According to page 14 of your performance plan, procedural disenrollments during the unwind were 25%. While this procedural denial rate has now declined to 12%, how has the department improved processes to minimize the administrative denials that lead to eligible folks no longer being enrolled? (Rep. Brown)**

Response:
The disenrollments during the PHE Unwind parallel our enrollment growth and align with our February 2024 budget forecast.

Our continuous coverage unwind webpage details Colorado's unwind experience.
Our data indicates that our procedural denials during the PHE Unwind were higher than historic prepandemic levels, while our income-based and other qualified eligibility-based denials were far below historic (about half). This is not unexpected; we expected that individuals who regained employment and the related employer-sponsored coverage during the PHE, would not consistently respond to our renewal inquiries, or our requests to verify income, both of which are referred to as "procedural" reasons for losing coverage.

The good news is that the procedural denials during the months of May through November 2024 — post the PHE Unwind — are now below the 12% prepandemic norm, but we have more work to do.

HCPF will be implementing an important new policy in January 2026 that allows continuous coverage for kids ages 0-3 that allow kids to stay covered. We will be studying options for coverage for other populations as authorized by 23-1300 and produce a report for the general assembly next year.

Ongoing strategies to reduce procedural denials:

- **Continued outreach using update your address and take action on your renewal toolkits:** The Department created toolkits and partners with Regional Accountable Entities (RAEs) to assist in outreach to members during the renewal process. The Department transcreated toolkit materials to raise awareness of renewals and

encourage members to update their addresses into 11 languages. The Update Your Address campaign encourages members to update their address and contact preferences so that they can be reached with important coverage updates and information. Materials in the Take Action on Your Renewal toolkit are designed to encourage members to look for their renewal paperwork in the mail and PEAK mailbox and take action when they get them. We also put in place a state centralized Return Mail Center to manage member contact updates and update addresses.

- **Continuing to Improve Automation: $0 Income Strategy (e14 waiver)**: For individuals with a previously-verified attestation of zero-dollar income, if the state has checked all available income data sources in accordance with its verification plan and no information is received, the state may consider the previously-verified income determination in the beneficiary's account as reliable under 42 C.F.R. § 435.916(b)(1) in conducting an ex parte renewal without requesting additional information or documentation of income.
- **Continuing to Improve Automation: 100% FPL (e14 waiver)**: For individuals with previously-verified income at or below 100 percent of the FPL, if the state has checked all available income data sources in accordance with its verification plan and no information is received, the state may consider the previously-verified income determination in the beneficiary's account as reliable under 42 C.F.R. § 435.916(a) in conducting an ex parte renewal without requesting additional information or documentation of income.
- **Using SNAP/TANF data to renew (e14 waiver)**: Enroll and/or renew Medicaid eligibility for Modified Adjusted Gross Income (MAGI) or non- MAGI-based individuals based on gross income findings from SNAP or TANF. This process will have to be modified to continue after June 2025 based on new guidance from CMS.
- **Pausing Terminations for LTSS members (e14 waiver)**: Delaying procedural terminations for beneficiaries while the state conducts targeted renewal outreach.
- **Continuing enhanced outreach during reconsideration period**: Implemented targeted text message outreach to people who were procedurally denied, but are still eligible during the 90 day reconsideration period. During the 90 day reconsideration period, members can complete a renewal and have coverage backdated to their renewal date.
- **Improving member correspondence**: Since July 2024, we've reviewed and updated 55 common member eligibility communications and are meeting with stakeholders to plan significant improvements to the renewal packet over the next 12 months. The goal of this work is to continuously improve our communication with members so they know what action they need to take and when to keep their Medicaid coverage or transition to other coverage if they no longer qualify.

Ongoing improvements to the online portal, PEAK, are also important to ensure members who choose a self service renewal option have a better member experience. We've upgraded the ability of PEAK to ensure larger documents can be uploaded and are making other improvements based on user feedback.

2. **If HCPF had to do this all over again, how would the Department improve member experience and significantly decrease the likelihood that members are kicked off for administrative reasons? (Rep. Brown)**

Response:
We would have been in a better place if all the system and county investments, advances and innovations we have made in the last few years and are making now would have been completed before the PHE Unwind started. To this end, we're planning several projects to continue to improve the member experience and drive down Colorado's procedural denials and have a budget request for consideration this year to drive improvements in our county infrastructure. Consider the below.

Investing in County-Administered Infrastructure
Colorado Medicaid is a state supervised, county administered eligibility and enrollment system. That means counties and eligibility sites process Medicaid applications and renewals. We're pursuing several strategies to continue to grow this infrastructure:

- **Senate Bill 22-235 County Administration of Public and Medical Assistance Programs:** provides a long term plan to improve county administration of eligibility and enrollment activities, including resourcing our state-county infrastructure, addressing county staff wage rate gaps, advancing the eligibility tools employed by county workers, and more. This report was released to the legislature on November 1, 2024 and many of its transformational recommendations are part of HCPF's FY 2025-26 budget request.
- **A funding request in FY 2025-26 HCPF/R-07 and CDHS/R-01 of nearly $44.5 million** in new federal, State and local funding, requests funds to align with the needs outlined in the SB 22-235.
- The **Joint Agency Interoperability (JAI) project** will advance county consistency through the use of shared, universal tools that support counties in eligibility task and document management. Target implementation: 2026-2027.
- The **Colorado Benefits Management System (CBMS) Vision and Strategy project** is driving alignment and clarity around CBMS operational advances, infrastructure and priorities. Target completion date: June 2025.

Improving automation & processes
Automation is critical to improving the member renewal experience and reducing county workloads. About 60% of our Medicaid & CHP+ renewals are processed without human intervention - member or county worker - which is a significant and meaningful improvement over the 33% average during the PHE Unwind. As part of the funding request in **HCPF/R-07**, we are looking towards investments into additional automation and improvements that will increase the ex parte rates even higher. In addition there is automation such as continued

efforts on intelligent character recognition (ICR) to streamline processes for eligibility workers and improve member experience.

During the PHE, the federal government allowed several temporary flexibilities that support greater automation, making it easier for states to perform renewals and keep more eligible people covered. These flexibilities were set to expire in June 2025, but the Centers for Medicare and Medicaid Services (CMS) recently provided guidance to states on ways to make some e14s permanent (with adjustments). The full list of options and our analysis of those options were shared with stakeholders and posted online. Some waivers will still sunset June 30, 2025.

We are also working on long term strategies to make it easier to stay on Medicaid for those that qualify, including:

- Continuous Eligibility Coverage for Children 0-3 Years and for Adults Released from Incarceration has been approved by CMS, effective January 2026
- Expand Presumptive Eligibility in allowable eligibility categories for Hospitals (SB 24-116 and HB 24-1229)- pending federal approval, would be effective January 2026. This will help those who do not have coverage but are likely eligible connect to coverage faster while their full eligibility is processed.

During the unwind, we implemented a new temporarily funded escalation process to help applicants and members if they need state assistance to successfully navigate standard county eligibility processes. Members can escalate any issue related to financial or functional eligibility, including case issues, long term care, customer service and general complaints. We are requesting funding to continue it as part of **HCPF/R-07**.

Background and Clarifications

For those who are new to the process and the PHE Unwind linguistics, we are sharing insights on the PHE Unwind that might be helpful, in complement to the above.

Administrative denials do not mean that the disenrollment was incorrect. It means we do not have proof based on current information in our eligibility system through various automatic interfaces that the individual still qualifies for coverage. The most common verifications we were missing during the unwind were related to proving current income. We accept self attestation of income at application but are federally required to verify that income is correct with proof of current information including income during the renewal process in order to keep an individual enrolled. In the case of individuals "locked" into coverage during the pandemic, the information we had from the original application when we had a severe economic downturn and nearly 11.7% unemployment (vs. 4% now) may never have been fully verified or was several years old. Our eligibility income indicator is secured through an interface with EquiFax. Our eligibility process, however, takes an extra step to make sure that the "over income" information received through these automated or available resources is accurate before disenrolling the household based on that information. Specifically, a renewal packet is released to the household after receiving the over income insight, and that renewal

is populated with as much information as we have to make the completion easier. That renewal packet includes an invitation to correct income or any other information reflecting their household and to resubmit it. If the household does not respond, that is counted as an Administrative (sometimes called Procedural) denial.

Our goal is for Coloradans to be connected to the coverage for which they qualify. HCPF worked with health plan partners to conduct targeted outreach to all individuals up for renewal to encourage them to fill out their renewals in order to stay covered. We transitioned many children of families over the income limits for Health First Colorado to the CHP+ program and worked closely with Connect for Health Colorado as some families could benefit from coverage offered through the marketplace. We are continuing this collaboration for all members up for renewal with our health plans and with Connect for Health Colorado. We also collaborated with private insurance carriers to ensure they were working to connect disenrolling Medicaid members back to commercial carrier programs, such as employer sponsored and individual.

3. **What is the department doing to help protect safety net providers that have been struggling in the wake of the unwind?(Rep. Brown)**

Response:
Many safety net providers are struggling right now. During HCPF's Joint Budget Committee hearings on January 6th and 13th, an option to provide additional financial support to safety net providers was presented for consideration including the use of the Colorado Hospital Affordability and Sustainability Enterprise (CHASE) fee to support safety net providers this fiscal year and next. Specifically, by moving to 99.2% of the FPL, $54 million additional funds became available this fiscal year. Further, the JBC Analyst presented an option to the JBC to leverage CHASE funds in fiscal year 2025/26. The JBC will be considering options through their regular budget process.

Note that FQHCs are paid on a cost basis. As their costs go up, HCPF Medicaid payments rise as well. While there is a timing gap between when the costs move and when the payments adjust, CHASE funds could be leveraged to address that gap.

We also wrote two communications to the federal government in the last year supporting the increase in funding to the FQHCs, and we are awaiting the federal government's decision on whether additional monies will be released to FQHCs in March.

Colorado Medicaid can only pay for services for individuals who are enrolled in our programs. For those no longer enrolled but who may be eligible, the only option to get covered is to re-apply. The fastest option for many individuals seeking coverage is online through PEAK. We have been working with providers to train them on how to use PEAK or work with a local Certified Application Assistance Site (CAAS) to help individuals enroll. We have 143 CAAS sites statewide, and some are located within hospitals or clinics to help individuals on site. Many

CAAS sites are also trained by Connect for Health Colorado as assisters so can help individuals who may benefit from a marketplace plan if they are over income for Health First Colorado or CHP+. Individuals who apply CHP+ through PEAK can get a real time eligibility determination, and anyone who applies and is deemed eligible for medical assistance is covered back to their application date. Providers are paid for those services which can reduce their uncompensated care costs.

In January 2025, we launched a new program, Cover All Coloradans, to provide coverage to a population that was previously not eligible. This will further help our safety net providers as these individuals now have a payer source. Currently 10,600 kids and pregnant people have been enrolled.

Below are the additional state actions to reconnect people who may still qualify to Medicaid:

- We outreached to more than 350,000 households who were previously enrolled with information on Coverage Options, including Medicaid.
- We are collaborating with county partners to work through any remaining renewal backlogs and work tasks to get members covered back to their renewal date, as appropriate.
- We put in place a state centralized Return Mail Center to manage member contact updates and update addresses.

4. **We've heard from providers and communities about the impact of Medicaid disenrollment, and we understand that many providers are seeing increased numbers of uninsured Coloradans. How will Colorado's new safety net absorb the cost of this disenrollment and increase in uninsured clients?**

Response:
HCPF worked with providers throughout the unwind of the PHE-related continuous coverage provisions. We are aware enrollment changes have caused a great deal of disruption for providers and that providers are reporting higher levels of uninsured patients. We won't know the official uninsured rate until the Colorado Health Access Survey is released in the fall of 2025. Further, we are anticipating an uptick in members getting connected to coverage through January 2025 enrollments. January represents a very popular and impactful enrollment period for employers (who traditionally provide benefit coverage to about 50% of Coloradans), Medicare and the Connect for Health marketplace. We will have more insights into that by the end of February.

There are ongoing efforts that HCPF employs to support our providers as well as new opportunities we have identified or that we are implementing to further support our providers. Several are outlined below.

New Opportunity - CHASE Fee

There is an opportunity to provide targeted increases to support safety net providers while using financing offsets, such as from the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), to help balance the impact on the State's budget. This year, the Department agreed to - and the CHASE Board approved – a change to the reimbursement methodology that increased net payments to hospitals by $54 million for the previous two federal fiscal years: FFY 22-23 increase is $32.7 million and FFY 23-24 increase is $19.3 million. The General Assembly could choose to pass legislation to use some portion of that amount to offset the General Fund to enable a targeted rate increase in provider payments, such as safety net providers. Similar actions to leverage available CHASE dollars were taken by the JBC in FY 2010-11 ($150 million) as well as in FY 2020-21 with HB20-1386, which authorized $161 million of CHASE cash fund as Medical Services Premiums General Fund offset.

CHASE Support for Rural Hospitals

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

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

New Coverage to Address Uninsured - Cover all Coloradans

Cover all Coloradans (HB22-1289) provides Medicaid and CHP+ look-alike coverage for children ages 18 and under and pregnant people who meet all eligibility requirements for Medicaid and CHP+ but for immigration status. This coverage expansion is expected to support safety net providers by covering historically uninsured individuals. As of January 2025, 10,600 individuals were enrolled into this new coverage providing a payer source for previously uncompensated care.

Medicaid reimburses Federally Qualified Health Centers (FQHCs) based on the cost of providing care, and Medicaid reimbursement for rural hospitals in aggregate is 96% of their cost of providing care (see Table 1). While this is a favorable aggregate payment rate for rural hospitals and higher than their urban counterparts, the aggregate findings mask the varied outcomes for individual rural hospitals, some of which face very different financial situations. Also, rural safety net providers struggle to cover their full operating costs due to low patient volumes and a higher proportion of patients covered by public payers compared to private payers. According to data sourced in the Colorado rural Health Center's *Snapshot of Rural Health in Colorado 2024*[1], for rural hospitals, approximately 54% of their patients are covered

by public payers or are uninsured and about 46% covered by private insurance. Further, while rural Critical Access Hospitals (CAHs) are paid on a cost basis by Medicare, through sequestration, CAH Medicare reimbursement rates are subject to a 2% reduction through 2032, meaning CAHs are currently paid below cost of care provided to Medicare patients.

Support for rural providers

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

RAE Support for Rural Practices

In addition to the overall requirements of the Regional Accountable Entities (RAEs) to support providers and provide practice transformation, HCPF has added specific requirements for the RAEs to provide resources and tools to rural providers in ACC Phase III. RAEs must design and implement strategies to enhance the financial and technical support of their contracted providers in rural communities. This includes providing shared resources, condition management programming, supporting communication tools and population health analytics to rural providers. RAEs may also fund investments in needed and shared infrastructure and services across rural hospitals and clinics (e.g., care coordination models, software, assistance connecting to and utilizing state HIT systems, etc.).

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

Table 1: Payment to Cost Ratio 2023, by Geographic location. Self-reported financial data by hospitals.

Location	Medicare	Medicaid	Commercial	Self Pay	CICP/Other	Total
Frontier	0.87	0.96	0.92	0.67	1.10	0.91
Rural	0.74	0.96	1.45	0.89	0.58	1.00
Urban	0.72	0.77	1.67	0.13	0.86	1.00
Grand Total	0.73	0.79	1.63	0.25	0.84	1.00

***County designations are sourced from the Colorado Rural Health Center and available at: https://coruralhealth.org/[3]**

Maternal Health

5. **There was a new doula program and I believe about a dozen doulas are now certified. How many have been able to perform the work? Have they been reimbursed for this? How many and how long did it take? I have heard from people that are doulas that they are not getting paid yet for their work. (Rep Feret)**

Response:
While the Department does not certify doulas, since the benefit went live July 1, 2024, we have enrolled 30 doulas with 95 applications in the queue. Of those 30 enrolled doulas, 16 have billed the Department, 15 have been paid for services and 43 members have received services.

The average claim processing turnaround time at the Department is four days. Delays in claims payments are due to claim denials, which result from invalid claim submissions or from providers who bill for services but have not yet enrolled in Medicaid.

The Department understands that most of these providers may be new to insurance billing, so HCPF staff created a quick enrollment guide and held open office hours and meetings with individuals as requested. The Department is also convening a Doula Advisory Committee, composed of doulas, hospital administrators and advocates to help identify and address challenges for doulas and members in standing up this new benefit.

Provider Payments

6. **What is the average payout timeline from submission of invoice to reimbursement? How many of them have been escalated? If we can break it out by type of provider and payout timelines, that would be helpful.(Rep Feret)**

Response:

HCPF processes about 40 million claims each year. The average processing timeline is 4 days or less across all medical provider types. Pharmacies are paid on a weekly basis, but the electronic claim is processed within seconds of receipt. Behavioral health claims are adjudicated by the RAEs. Timeliness performance results are as follows: over 91% of clean claims within 7 days and over 99% of clean claims within 30 days

To support timely reimbursements, HCPF provides detailed billing instructions and online manuals to guide providers in filing claims successfully. Additionally, our fiscal agent, Gainwell, operates a provider call center handling up to 15,000 calls per month, providing real-time support for claims or billing issues. Call center wait times average under 60 seconds, ensuring providers can quickly get the help they need.

For Home and Community-Based Services (HCBS), the unwind of the PHE emergency resulted in delays in financial and functional eligibility determinations, which caused claim denials and payment delays. As a result, HCPF implemented a temporary system edit that allows providers to bill for previously approved services even if there is no active prior authorization for home and community waiver services. Further, the Provisional Provider Payments (3P's) program was created to provide two rounds of provisional payments in the form of short-term advances to Long Term Services and Supports (LTSS) providers that demonstrated the greatest need. The first round of payments took place on February 5, 2024, and the second round of payments were swiftly issued on March 25, 2024. Overall, there were 140 providers who took advantage of this program, resulting in over $17M in funds being distributed. Each provider had a customized repayment option presented to them during the initial application process to ensure sufficient support and time was given in fulfilling their loans. Repayment commenced as of July 1, 2024, and HCPF continues to work and support each provider on a case by case basis during the repayment period.

7. **Do you all have any sort of accountability if you do not payout timely? If not, what kind of recourse can providers have when payout is delayed? (Rep Feret)**

Response:
HCPF pays providers faster than most commercial payers, finalizing claims in 4 days or less on average. Providers have 365 days from the date of service to file claims. For claims filed without errors (referred to as "clean" claims in federal regulation), state Medicaid programs are required to pay 90% within 30 days and 99% within 90 days. HCPF exceeds these standards, paying over 99% within 30 days and nearly 100% within 90 days. HCPF's contracted Managed Care Entities (MCEs) also pay 99% of clean claims within 30 days, all publicly reported on the BH Accountability Dashboard.

The Centers for Medicare & Medicaid Services (CMS) may impose various penalties on State Medicaid Agencies for noncompliance with federal regulations. The primary penalty is withholding federal Medicaid matching funds, but it can also include Corrective Action Plans (CAPs), enhanced federal oversight, and other measures.

HCPF maintains detailed billing instructions including online billing manuals to help providers successfully file claims and be paid as quickly as possible. HCPF's fiscal agent, Gainwell, also maintains a provider call center for providers to get real-time assistance with questions about claims or billing problems. Wait times for the provider call center average less than 60 seconds, making it easy for providers to get the assistance they need in a timely manner.

There are a limited number of situations where provider reimbursements may take longer. For example, provider claims errors may trigger system edits that will deny payment, requiring the provider to correct the errors prior to payment. In instances of identified or likely fraud, waste, or abuse, HCPF can take additional time to review claims prior to payment to safeguard resources and ensure program integrity.

8. **Do you allow for any accountability of timely payouts to be crafted into your contracts with the community and the providers? (Rep Feret)**

Response:
HCPF does not create individual contracts with providers; instead, providers sign a Provider Participation Agreement (PPA) upon enrollment. HCPF adheres to federal regulations requiring 90% of clean claims to be processed within 30 days and 99% within 90 days.

The Regional Accountable Entity (RAE) contracts have timeliness standards that require 99% of clean claims paid or adjudicated within 30 days. RAEs are held accountable for this requirement through traditional contract management processes. The following table shows the RAE's most recent performance for this requirement:

	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
A.% of clean claims paid or adjudicated within **7 days**	92.54%	84.56%	90.88%	91.69%	93.49%	93.42%	93.42%
B.% of clean claims paid or adjudicated within **14 days**	5.26%	2.70%	2.58%	2.41%	1.91%	5.82%	5.82%
C.% of clean claims paid or adjudicated within **30 days**	1.82%	12.42%	5.66%	7.43%	3.98%	0.75%	0.75%
Total % *(Rows A+B +C)*	99.62%	99.68%	99.12%	99.86%	99.38%	99.99%	99.99%

Under the State Controller's contract template and Colorado's Prompt Payment Statute, the Department is required to pay all invoices within 45 days of receipt. This requirement applies to every vendor contract the Department enters into, provided the invoice accurately reflects work that was completed in accordance with the contract terms and conditions.

<u>Process Improvement; Inter-department communications (Rep. Feret)</u>

9. **A barrier for case managers is the ability to directly talk with the financial eligibility technicians. Case Managers report often having to be on hold just like their clients to reach their colleagues. Do you have a direct means of communication between the two offices to streamline comms and workflow? (Rep Feret)**

Response:
HCPF expects and encourages communication between Case Management Agencies (CMA) and the Counties, including establishing direct contact for questions and member escalations. During the unwinding of the Public Health Emergency, HCPF provided each CMA with a list of escalation contacts at every county to be reached in the event the CMA had questions or concerns about the financial eligibility of shared members. It is our understanding that this process has been effective for most case management agencies; however, seeing your question, it is clear some operational challenges exist, and we will follow up accordingly.

In addition, HCPF continues to promote intentional efforts to propel improved collaboration and shared information across these two critical partners. Through the implementation of streamlined eligibility, which created an interface between the Care and Case Management (CCM) system and the Colorado Benefits Management System (CBMS), HCPF has begun to reduce the administrative burden for counties and CMAs of sending paper documents or emails. While streamlined eligibility has produced additional challenges due to known system issues, the benefit of the interface will reduce the need for manual communication processes over time. HCPF has also increased communication and coordination so that guidance on IT systems related to financial and functional eligibility is being shared more holistically with both CMAs and counties. This includes newsletters and cross-sharing of information at the CCM and CBMS Technical Assistance Support Calls.

Finally, as part of HCPF's 2025 county administration rule revisions, HCPF will expect counties to develop internal controls that clarify expectations, roles, and responsibilities for communicating and working with CMAs. These new rules will be effective July 2025. HCPF will work to support counties in operationalizing the appropriate internal controls to streamline their work and better coordinate with the functional eligibility processes. HCPF also continues to work towards contract and regulation alignment to ensure clear expectations around coordination and collaboration between CMAs and counties.

During upcoming joint stakeholder meetings, HCPF will also continue identifying additional opportunities to improve ongoing communication and collaboration between CMAs and counties.

<u>Medicaid and the RAEs: Operations and Options</u>

10. **Help us understand the operational complexities of the RAE program from a provider perspective. It's our current understanding that all RAEs have different credentialing, reimbursement and operational processes? This represents a clear challenge for mental health providers that are attempting to serve constituents across county lines. Why is this process such a challenge and how will you make it simpler? In a state that reports ongoing shortages in the behavioral health workforce, particularly among providers of color, this represents a barrier that HCPF could very clearly make easier. This is NOT a new issue; however, the Department continues to allow RAEs to create rules and policies that make reimbursement and service provision a challenge. (Rep English)**

Response:
We have a unique Medicaid delivery system in Colorado (referred to as the Accountable Care Collaborative, or ACC). Within the ACC, behavioral health services are reimbursed through the capitated managed care organization (MCO) benefit, which is administered by Regional Accountable Entities (RAEs). Forty-one state Medicaid programs have some form of managed care program.

In order to participate in Medicaid, behavioral health providers first enroll with the Department, then go through a credentialing and contracting process to become a provider with one or more RAEs. This is similar to a provider credentialing with multiple commercial payers. As regional organizations, each RAE has flexibility in how they credential, operate and reimburse providers though all of these processes must meet standards set in state contract and state and federal managed care regulation or statute.

We recognize the challenge this can present for providers that want to provide behavioral health services for members, particularly smaller or independent practices that aren't associated with larger safety net or health systems. HCPF has worked with a collaborative of these small and independent providers and a third-party contractor to identify and monitor key issues and recommendations for improvement and has seen improvement in provider satisfaction with HCPF and with their RAEs. More information about identified issues and work to improve the experience for these providers can be found on the IPN Collaborative webpage.

Below are some of those challenges as well as solutions we've identified and implemented or are in the process of implementing to improve provider experience among other benefits:

- **Challenge:** RAEs must establish a statewide network of behavioral health providers. This means that if a behavioral health provider wants to provide services for members

across regional lines, they must go through the contracting and credentialing process for up to five different organizations (currently there are seven RAE regions with five organizations serving as RAEs).
    - **Solution:** In ACC Phase III (the next iteration of contracts with RAEs beginning on July 1, 2025), we are reducing the number of RAE regions. The regional model is important for a state like Colorado that has many communities with varying needs where it is beneficial to have an organization with that regional expertise supporting members and providers. However, we want to balance that need for regionality with more standardization and consistency for providers.
    - **Proposed Solution:** Based on recommendations from the provider collaborative, HCPF has submitted a budget request item to centralize the credentialing for all behavioral health providers. If passed, this means that providers will only complete the credentialing process one time to be able to contract with each RAE.
- **Challenge:** Providers have to work with different organizations that have different operational procedures. It can be challenging to keep different processes straight, know who to contact, etc.
    - **Solution:** RAEs have worked hard to improve their relationship with and the experience of these providers. For example, one RAE improved their process to proactively outreach providers to resolve billing issues, implemented system updates for easier navigation and improved their forums for engaging providers and the educational resources available to them. Another RAE streamlined their credentialing and contracting to create a more efficient process for providers, while also engaging extensively with providers to provide education, answer questions and ensure they have the resources needed to provide care to members.
- **Challenge:** Given that all RAEs operate like separate health plans, they may have varying reimbursement policies.
    - **Solution:** HCPF has established a number of directed payments for key services, which sets a minimum payment amount RAEs must follow when contracting with providers. Additionally, as HCPF has worked with BHA on the expansion of the behavioral health safety net, there are new payment methodologies for the new safety net providers. RAEs will reimburse Comprehensive Providers using a Prospective Payment System (PPS) that pays providers a standard daily rate for any qualifying service provided to a member, regardless of what or how many specific services were rendered on a single date of service. Additionally, RAEs must also offer the Comprehensive Providers in their region a value-based payment arrangement for meeting measurable outcomes that improve member access to quality care. Essential Providers will receive minimum reimbursement rates for selected essential services. More information about the Comprehensive Provider PPS and the Essential Fee

Schedule can be found in the July 2024 State Behavioral Health Services Billing Manual.

Additionally, HCPF has prioritized health equity to improve outcomes for our members. One key accountability driver has been implementing the first-of-its-kind Health Equity Plan and making health equity a contract requirement for our providers since July 1, 2022. One of the focus areas of our health equity plan is **behavioral health**, which has included investments to strengthen and transform behavioral health care through collaboration with the Behavioral Health Administration, investing in the behavioral health safety net and improving behavioral health access.

All RAEs are required to submit health equity plans, in alignment with HCPF's health equity plan, that identify the unique disparities members face in their region and local communities, while developing specific interventions to address those disparities. Plans prioritize closing health inequities by improving health outcomes for marginalized, underrepresented, and underserved communities. As an example, one RAE has the following goal in their health equity plan: Direct a data-driven strategy to recruit and maintain a provider network of culturally and ability-aligned providers based on the needs CO Access members in their communities. RAE's are also actively developing recruitment strategies to build, recruit and retain a culturally responsive and ability aligned provider network (as part of their Health Equity Plans).

We recognize that it is an ongoing process to address a topic as vast as health equity. In ACC Phase III, we've added additional requirements for the RAEs to support our overall goal to improve health equity and reduce disparities for our members. These include a personnel position dedicated to Equity, Diversity, Inclusion and Accessibility (EDIA) efforts throughout the RAE and in their communities. Additionally, RAEs are required to form a health equity taskforce of internal staff, community partners, providers, and members, including members with disabilities, to discuss equity and disparity issues within their region.

Mental Health Parity in Medicaid

11. **With regards to mental health parity implementation in Colorado, how is this law currently being implemented, in specific detail? (Rep. English)**

Response:
The Department of Health Care Policy and Financing (HCPF) is responsible for monitoring and oversight of Health First Colorado's compliance with parity requirements in accordance with all federal and state regulations. In accordance with Colorado Revised Statutes § 25.5-5-421, which was enacted by Colorado House Bill 19-1269, every year HCPF performs analysis of parity compliance and prepares an annual Mental Health and Substance Use Disorder Parity Report (Parity Report). This comprehensive process ensures that behavioral health parity standards are met for all Health First Colorado members. This report details HCPF's findings from an analysis of the managed care entities' policies and procedures to ensure their

compliance with all federal and state parity laws. HCPF submits the report to the Colorado state legislature, the Centers for Medicare and Medicaid Services (CMS), and posts them publicly on the Parity webpage and Legislator Resource Center webpage. HCPF follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS's parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs," and in following with the requirements in C.R.S. § 25.5-5-421 and evolving guidance from CMS. A full description of the parity assessment process can be found in the Methodology section of the Parity Report.

There are additional avenues where HCPF collects information that is vital to the robustness of parity enforcement, and much of this information is shared in the Parity Report. HCPF considers stakeholder feedback vital to the monitoring of parity. HCPF staff engage and seek out input in multiple opportunities and formats throughout the year to ensure ongoing compliance with federal and state parity laws, but also to inform the analyses of policies and procedures. A summary of the stakeholder engagement and feedback received can be found in the Stakeholder Engagement and Feedback section of the Parity Report. HCPF also contracts with an external quality review organization to perform an annual audit of Colorado Medicaid's managed care entities' (MCEs') utilization management policies and procedures as well as a sample of prior authorization denials to determine whether the MCEs, which include the Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs), follow federal and state regulations and internal policies and procedures that impact parity. A summary of the external audit can be found in the Parity Report, and the full report can be found on HCPF's Parity webpage. HCPF also performs ongoing monitoring, evaluation, and review of parity compliance throughout the year. Monitoring activities include regular communication with the MCEs, meetings and events with stakeholder groups, or direct contact with the Behavioral Health Ombudsman office, practitioners, or members. Any concerns that are raised are analyzed and addressed as they are identified. A summary of these activities are included in the Parity Monitoring During Reporting Year section of the Parity Report.

12. **I know that a Medicaid report was released in 2023 that provided some information on this; however, billing data was lacking. How are constituents supposed to know that they're truly getting access to the services they're entitled to by law? (Rep. English)**

Response:
For information regarding the annual Colorado Medicaid Parity Report and compliance activities and the Behavioral Health Rates Reform, please see our response to your question about mental health parity implementation. In addition, HCPF takes action to inform and educate members and the public about parity, to act as additional sets of eyes to identify possible parity problems. HCPF includes specific, plain language statements about parity policies and how to submit a complaint to the Behavioral Health Ombudsman Office of

Colorado in the Health First Colorado Member Handbook and on HCPF webpages. Furthermore, all managed care entities (MCEs) are required to include this statement on their websites and in service coverage denial letters.

All MCEs are required to work with HCPF to provide a Member Handbook that includes descriptions to all services available to them, including mental health services. In addition to this, MCEs are required to host websites with information for members about the services available to them, providers in their network and contact information for further questions. Outside of the MCEs, primary care providers also work with members to connect them to mental health services when needed.

13. **As is true with many other healthcare metrics in Colorado, our diverse communities are disproportionately impacted by mental health challenges. What state-level data is available that can help us understand what services are being received by Black and Brown Coloradans? (Rep. English)**

Response:
Medicaid serves one in four Coloradans. Fifty percent of the Medicaid population identifies as people of color. Forty-three percent of the population receiving Medicaid behavioral health services identify as people of color. For a better picture of the state as a whole, the All Payer Claims Database (APCD), managed by the Center for Improving Value in Health Care (CIVHC), can be consulted. The APCD contains data from Medicaid, Medicare and commercial payers. The Colorado Health Institute, with funding support from state agencies and other sources, also provides a bi-annual Colorado Health Access Survey that includes state-wide data on access to care. This type of report is essential because it reviews not just the utilization of services, but also the experiences of Coloradans including those who needed but did not receive services and why.

HCPF, in partnership with the BHA and CDPHE, are actively working to address workforce shortages, including building out team-based models of care. That includes reimbursement models that support clinical experts, recovery coaches, individuals with lived experience, and community based health workers. As loan forgiveness programs, target recruitment, and career ladder programs help build the clinical workforce, including trusted community members as part of the care team allows for more individuals from diverse backgrounds to provide support, outreach, education, and lifeskills. This creates a workforce that is more representative of the community they serve and helps connect patients and keep them engaged in care.

As of July 1, 2025, HCPF will be adding Community Health Workers to our workforce. Current research demonstrates that Community Health Workers (CHWs) and Community Health Representatives (CHRs) improve health-care outcomes and promote health equity. Additionally, CHWs/CHRs play a vital role in providing culturally competent care that tailors a member's beliefs, values, and social environment to the care that they are receiving from the

health system. CHWs/CHRs often accomplish this by incorporating cultural and/or faith-based beliefs into interventions. Examples include providing services in the member's preferred language or having organizations employ CHWs/CHRs who are from the same geographic, linguistic, or racial and ethnic community. HCPF is committed to supporting CHWs/CHRs in their work to improve access to health care and advancing health equity.

14. **This issue is critical as we know that mental health funding continues to be a challenge for communities across Colorado. Behavioral health providers struggle to get credentialed and paid adequately for services rendered to patients and insurers drive the care that is covered. Parity was passed to ensure that funding would be provided to mental health services at the same rate as physical health services - and we know that physical health services continue to be reimbursed at significant rates (even though there are issues with THIS process as well). We would like to see data that shows a clear comparison between the physical health services being reimbursed by both Medicaid in Colorado and the mental health services being reimbursed as we know that in 2024, 3 in 5 Coloradans reported having experienced mental health strain throughout the year (https://www.cpr.org/2024/08/13/colorado-mental-health-concerns-poll/) . Where can we find clear data and information that would assist us in understanding this reimbursement discrepancy? (Rep. English)**

Response:
Above and beyond federal parity requirements, HCPF is dedicated to supporting behavioral health providers and the essential services they provide to members. HCPF welcomes exploring any opportunity to bring additional funding into Colorado's behavioral health system, especially in the tight fiscal environment that Colorado currently faces.

HCPF has worked hand in hand with the General Assembly, members, providers, and other stakeholders to implement transformative changes to our behavioral health system resulting in network improvement (more providers available), service expansion (more services available), greater access (higher utilization per person), and increased reimbursement (higher payments to providers). Since services vary wildly in length of time, professional training required, and cost of associated task, HCPF measures the access, utilization, and network size as an indicator of the health of the rates and benefits. By these measures, the Medicaid behavioral health benefits have steadily improved over the past five years.

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

Service expansion: Since 2017, the General Assembly has expanded behavioral health services and benefits multiple times, including:

- HB 18-1136, SUD Residential and Inpatient services

- SB 17-207 and HB 22-1214, Mobile Crisis Response
- SB 21-1085, Secure Transport services
- SB 22-131, Supportive Housing
- HB 22-1203, Mental Health Transitional Living

Greater access: Since the pandemic, the number of unique members utilizing services has continued to grow. In June 2019, the number of utilizers per thousand members was approximately 61. By the end of the Public Health Emergency (PHE) unwind in June 2024, the number of utilizers per thousand members was approximately 86, a 41% increase. As an example, the number of unique members receiving at least one 60-minute session of psychotherapy went from approximately 67,000 in FY 2018-19 to approximately 111,000 in FY 2023-24. This represents an increase of over 64%.

Increased reimbursement: Funds paid to provide behavioral health services have increased consistently since Fiscal Year 2018-19 when Colorado last saw the current level of Medicaid enrollment. The increases to contracted provider rates were built into capitation rates in the same manner as is done on the physical health side for the HMOs.

- More than $400M in additional funding to RAEs to increase Medicaid BH rates and access has been funded since 2018 through FY 2021-22. HCPF increased RAE behavioral health budgets by about 6% in FY 2021-22 (about three times the across the board increase provided to all Medicaid providers that year).
- About $600 million in additional funding has been provided to RAEs since FY 2018-19 to increase provider reimbursements and enhance behavioral health services and coverage. HCPF increased RAE behavioral health budgets by approximately 6% in FY 2021-22 (about three times the across-the-board increase provided to all Health First Colorado providers that year) and sustained that funding during FY 2022-23.
- In FY 2022-23, all RAEs increased rates for behavioral health providers, with a specific focus on expanding the independent provider network (IPN). The total dollars RAEs paid out to the IPN increased from $167 million in FY 2020-21 to $357 million in FY 2023-24, an increase of more than 100%.
    - The weighted average reimbursement rate for independent providers increased by 6.9% year over year between FY 2020 and FY 2021.
- For more information on Behavioral Health Rates, please see the HCPF Behavioral Health Rate Reform website and related reports.

The Centers for Medicare and Medicaid Services (CMS) explain that the Mental Health Parity and Addiction Equity Act (MHPAEA or commonly referred to as "parity") "makes it easier for Americans with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services. [Parity] requires coverage for mental health and substance use disorders to be no more restrictive than the coverage that generally is available for medical/surgical conditions." HCPF is dedicated to parity and ensuring that it is no more

difficult for people to access benefits for mental health and substance use disorder (behavioral health) than to use benefits for physical health.

It is not a violation of parity when reimbursement rates differ between behavioral health (mental health and substance use disorder) services and physical health (medical/surgical) services. Reimbursement rates are expected to vary for different services, and equality is not required by the parity rules. However, the methods used to establish rates and comparability between methods applicable to behavioral health benefits and physical health benefits are relevant to the requirements. The reimbursement methodologies are different but each are industry standards, take into account the delivery models and health care payer best practices, and are applied in a substantially similar and no more stringent method. The methods employed by Colorado Medicaid's Managed Care Entities (MCEs), including the Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs), are evaluated as part of HCPF's analysis of parity compliance, documented in the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Parity Report.

CCBHC Planning Grant

The following questions were combined into one response:

15. **I'm thrilled to see that the state received the CCBHC planning grant and will be embarking upon a stakeholder process to develop that implementation plan. How will you ensure the ultimate plan will demonstrate fidelity to the evidence-based federal CCBHC model? (Rep. Rydin)**
16. **Now that Colorado has received the CCBHC Planning Grant, we need to ensure that we are ready to submit a successful proposal to become a demonstration state to ensure quality, equitable care in our system and to bring in additional funding for our behavioral health system. What is the plan to maximize success?**

Response:
The Colorado Certified Community Behavioral Health Clinics (CCBHCs) Planning Grant will be a 12-month collaborative project jointly facilitated by HCPF and BHA. The grant requires states to work closely with federal partners such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) through regular strategy discussion and grant progress tracking meetings, and provide technical assistance to ensure fidelity to the national model.

The planning grant will provide HCPF the opportunity to contract with outside consulting organizations with considerable CCBHC implementation experience and expertise to guide efforts and ensure adherence to federal requirements. Furthermore, HCPF and BHA look forward to the robust and meaningful stakeholder engagement that will be central to the CCBHC Planning Grant project.

Prospective Payment System

17. **Is there a solid commitment from HCPF to continue the PPS payment model for CSNPs and to ensure that providers continue to be paid on prospective costs of providing care, which increase based on inflation and cost of staffing?**

Response:
Yes. HCPF is in the process of codifying the PPS payment model for Comprehensive Providers in Rule and in the Medicaid State Plan.