COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information #1 regarding Department staffing, turnover and personnel.

Legislative Request for Information #1 states:

> *All Departments -- Based on the Department's most recent available record, what is the FTE vacancy and turnover rate: (1) by department; (2) by division; (3) by program for programs with at least 20 FTE; and (4) by occupational class for classes that are located within a larger occupational group containing at least 20 FTE. To what does the Department attribute this turnover/vacancy experience? Do the statewide compensation policies or practices administered by the Department of Personnel help or hinder the department in addressing vacancy or turnover issues?*

The report includes information on Department staffing over the last fiscal year, including turnover and vacancy rate by department and office, turnover and vacancy rate by program and turnover and vacancy rate by occupational class, along with the Department's responses to the questions posed in the request.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director
KB/og

Enclosure(s): Health Care Policy and Financing FY 2021-22 Common RFI #1

CC: Representative Julie McCluskie, Vice-Chair, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Bettina Schneider, Finance Office Director, HCPF
Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Anne Saumur, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

HCPF Common LRFI #1 2021

Joint Budget Committee's Multi-Department Request for Information #1 regarding staffing, turnover, and personnel

November 1, 2021

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

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Department of Health Care Policy & Financing

I. Department Staffing, Vacancy, and Turnover

A. Turnover and Vacancy Rate by Department and Office

Below is the Department's FTE turnover and vacancy rate by office. The Department tracks this data by office rather than division, so information on the turnover and vacancy rate by division is not available.

Table 1 - Turnover and Vacancy Rate by Department and Office for FY 2020-21

Office	Number of Unique Positions	Turnover Rate[1]	Vacancy Rate
Executive Director's Office	30	0%	3%
Cost Control and Quality Improvement	45	16%	18%
Finance Office	132	8%	8%
Health Information Office	56	9%	30%
Health Programs Office	78	14%	15%
Medicaid Operations Office	158	8%	8%
Office of Community Living	104	10%	8%
Pharmacy Office	15	0%	7%
Policy, Communications and Administration Office	63	6%	14%
Total by Department	**681**	**9%**	**12%**

[1] Turnover rate is calculated as the number of times an employee separated from the Department in FY 2020-21, either voluntarily or involuntarily, divided by the total number of unique positions.

[2] Vacancy rate is the percentage of times in FY 2020-21 that positions have been vacant. This includes positions that separated prior to July 1, 2020 but remained vacant for a period of time in FY 2020-21.

B. Turnover and Vacancy Rate by Program

Below is the turnover and vacancy rate by program for programs with at least 20 FTE.

Table 2 - Turnover and Vacancy Rate by Program greater than 20 FTE for FY 2020-21			
Office	**Number of Unique Positions**	**Turnover Rate[1]**	**Vacancy Rate**
Member Call Center	30	30%	13%
Total by Program	**30**	**30%**	**13%**

C. Turnover and Vacancy Rate by Occupational Class

Below is the turnover and vacancy rate by occupational class within the larger occupational group of at least 20 or more FTE.

Table 3 - Turnover and Vacancy Rate by large Occupational Group for FY 2020-21			
Occupational Group	**Number of Unique Positions**	**Turnover Rate[1]**	**Vacancy Rate**
Accountant II	10	10%	0%
Administrator I	15	60%	33%
Administrator II	17	18%	12%
Administrator III	60	10%	12%
Administrator IV	62	8%	11%
Administrator V	17	6%	0%
Analyst II	10	10%	40%
Analyst III	39	13%	8%
Analyst IV	14	0%	14%
Compliance Specialist III	13	15%	8%
Compliance Specialist IV	10	20%	20%
Contract Administrator IV	11	9%	9%
Management	11	0%	18%
Policy Advisor III	20	15%	20%
Policy Advisor IV	12	0%	0%

Program Assistant I	12	0%	17%
Program Management I	32	13%	9%
Program Management II	43	0%	2%
Program Management III	12	8%	17%
Rate/Financial Analyst I	16	19%	13%
Total by Occupational Group	**436**	**11%**	**11%**

[1] Turnover rate is calculated as the number of times an employee separated from the Department in FY 2020-21, either voluntarily or involuntarily, divided by the total number of unique positions.
[2] Vacancy rate is the percentage of times in FY 2020-21 that positions have been vacant. This includes positions that separated prior to July 1, 2020 but remained vacant for a period of time in FY 2020-21.

II. Narrative

Based on existing historical survey data, the most frequently cited reasons for leaving employment are: 1) the opportunity for promotions that include additional pay; 2) better pay; and 3) dissatisfaction with a supervisor.

To attract and retain employees, the Department has: implemented focused executive coaching for the Senior Executive Team and Executive Leadership Team (two highest levels at the Department; continued to enhance employee engagement through its middle management leadership development program (in its second cohort now); expanding employee coaching; revising and streamlining the new employee orientation and first-year onboarding process; conducting monthly "all staff" meetings to ensure clarity of priorities and how their contributions and performance as a HCPF employee is making a meaningful difference in the lives of Coloradans who are struggling, have low-income, have a disability, who are marginalized, etc.; and, providing training to managers to more effectively use competency-based, in-range salary adjustments. The Department has also started to implement a more comprehensive learning and development model designed to provide staff both personal and professional development opportunities while also increasing awareness of jobs and carrier opportunities available inside the Department for employees who seek change, opportunity, and growth.

The statewide compensation policies, compensation ranges, and implementation rules continue to make competing with the private sector to attract and retain top talent a challenge. As the Department of Personnel and Administration noted in its FY 2022-23 Annual Compensation Report, "the average base salary 6.5% below prevailing market." In addition, while total compensation is important, the base pay only accounts for 69% of the State's total compensation package." This disparity, particularly in wages, is a constant source of concern when hiring staff. Base salary tends to be more important when it comes to negotiating and

provides more value to employees. This is exacerbated by the state's general policies to fund new positions and hire new staff at the minimum of the salary range.

The Department supports the idea around a merit pay program tied to performance, which would be a great step in the direction of bridging the pay gap that exists between the state and the prevailing market.

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1570 Grant Street
Denver, CO 80203

November 1, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information #2 regarding Public School Health Services.

Legislative Request for Information #2 states:

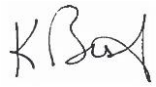
> *The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.*

The report includes information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars distributed to each school under the program. There are two programs under the Department's purview that provide funds for health services provided to students: The School-Based Center Program and the School Health Services Program.

The School Health Services Program provides health services as required in a child's Individualized Education Program or Individualized Family Service Plan, and the School Based Health Center Program provides primary care and mental health services. This report pertains to the School Health Services Program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,



Kim Bimestefer
Executive Director

KB/og

Enclosure(s): Health Care Policy and Financing FY 2021-22 Department RFI #2

CC: Representative Julie McCluskie, Vice-Chair, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
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Lauren Larson, Director, Office of State Planning and Budgeting
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Legislative Request for Information 2 states:

> *Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.*

EXECUTIVE SUMMARY

This report is presented to the Joint Budget Committee (JBC) of the Colorado General Assembly in response to Legislative Request for Information 2. Under the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and Title 22, C.R.S., public school districts are required to provide certain medical services for public school children. Additionally, school districts provide some level of health screening, nursing services and other medical support services for students. When delivered to a Medicaid enrolled student, some of these services qualify for Medicaid reimbursement. The School Health Services Program administered by the Department of Health Care Policy and Financing (the Department) allows Colorado public school districts, Boards of Cooperative Education Services (BOCES), and the Colorado School for the Deaf and the Blind (hereinafter collectively referred to as School Health Services Program Providers or providers) to access such federal Medicaid funds.[1]

Legislative Request for Information 2 requests information on the following:

- Types of Health Services Delivered and Number of Children Served

  Within the capacity of the specific School Health Services Program Provider, providers can receive reimbursement from Medicaid for health services that are medically necessary and provided to Medicaid enrolled clients as prescribed in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Beginning October 1, 2020 the School Health Services Program expanded and covered Health First Colorado enrolled students that have other medical plans of care (outside IEPs/IFSPs) where medical necessity has been established. Covered services may include direct medical services, including rehabilitative

[1] There are two programs under the Department's purview that provide funds for health services provided to students: the School Health Services Program and the School-Based Health Center Program. The programs differ in that the School Health Services program provides health services as required in a child's Individual Education Program (IEP), Individualized Family Services Plan (IFSP), or other medical plans of care and the School Based Health Center Program provides primary care and mental health services. A more in depth explanation of the two programs can be found on pages 2 and 3 of this report.

therapies, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, and Specialized Non-Emergency Transportation services.

During FY 2019-20, 19,836 enrolled children with an IEP or IFSP and in FY 2020-21, 20,026 enrolled children with an IEP, IFSP, or other medical plans of care received school health services reimbursed through Medicaid. Participation by Medicaid-enrolled clients is optional.

- How Services Meet the Definition of Medical Necessity

  For a School Health Services Program Provider to receive Medicaid reimbursement, the service must meet the definition of medical necessity. A determination of medical necessity is made through the referral and authorization process. Where required by Medicaid regulations, a qualified practitioner of the healing arts refers a client for services. The client's IEP, IFSP, or other medical plans of care, when developed according to the Colorado Department of Education procedures, serves as authorizing documents. The Department provides technical assistance and oversight monitoring to ensure providers comply with the requirement.

- Federal Dollars Distribution to School Districts

  For FY 2019-20, 55 School Health Services Program Providers received Medicaid reimbursement totaling $61,532,774. As the original expenditures of the medical service were incurred by a public entity using local tax dollars or General Fund appropriated to educational institutions, the Medicaid reimbursement is entirely federal funds. The federal funds are made available to deliver primary and preventative health services to Colorado's public school children identified and specified under the providers' Local Services Plan (LSP). The LSP written by the school district, with community input, describes the type and cost of services to be provided with the funds. In FY 2019-20 the most common area to use the funds according to a provider's LSP was to fund additional nursing services and mental health for all students.

BACKGROUND INFORMATION

There are two programs under the Department's purview that provide funds for health services provided to students: the School-Based Health Center Program and the School Health Services Program. This report pertains to the School Health Services Program.

School-Based Health Center Program

The School-Based Health Center Program was created in 1987 to assist in the establishment, expansion, and ongoing operations of school-based health centers

(SBHCs) in Colorado. SBHCs are clinics operated within a public school, charter school, or State-sanctioned General Educational Development (GED) building that provide primary health care and mental health services that complement services provided by school nurses.

Establishing a school-based health center is a community-driven process that requires multiple partnerships - between school districts, the medical and mental health communities and local and state funders - to be effective. The Colorado Department of Public Health and Environment does not run these clinics, but rather sets standards and provides some funding. SBHCs that enroll as Medicaid or Child Health Plan Plus (CHP+) providers receive reimbursement from the Department for their Medicaid claims and through CHP+ managed care organizations for their CHP+ services.

School Health Services Program

The School Health Services (SHS) Program was established in 1997 via SB 97-101 and allows School Health Services Program Providers to receive federal Medicaid funds for amounts spent providing health services to students who are Medicaid enrolled and have an IEP or IFSP. Starting October 1, 2020 as a result of state plan amendment 19-0021 the SHS Program expanded and allows providers to also receive federal Medicaid funds for providing services to Medicaid enrolled students that have other medical plans of care where medical necessity has been established. (Note: health services required in a child's IEP or IFSP are not covered by the SBHC Program, which provides primary health care and mental health services.) In addition, SHS Program Providers may receive reimbursement for Medicaid administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid.

The SHS Program Providers incur the original expenditures using local tax dollars or appropriated General Funds which draw federal matching Medicaid funds through the certification of public expenditures (CPE) mechanism. To draw federal Medicaid funds through CPEs, SHS Program Providers must participate in a federally-approved quarterly time study and submit quarterly and annual cost reports.

Under Colorado statute, SHS Program Providers are required to use the Medicaid funds received for health services for all students. Each participating SHS Program Provider must develop an LSP with community input to identify the types of health services needed by its students and must submit an annual report that describes exactly how the Medicaid revenue was spent in accordance with its LSP.

The SHS Program is administered jointly by the Department and Colorado Department of Education. The Department draws and disburses the federal Medicaid funds, conducts the federally-approved time study, administers the quarterly and annual cost report and certification processes, and conducts comprehensive reviews to ensure compliance with federal requirements. The Department of Education provides technical assistance related to the development of LSPs and annual reports and reviews and approves LSPs.

PROGRAM OVERVIEW

The SHS Program delivers additional health services to Colorado public school children each year without additional General Fund expenditures. Using the disbursed federal funds within a health service delivery process established through the LSP, school districts address some of the health care needs unique to their communities. Additionally, the SHS Program improves learning environments by providing students increased access to health care services and improving the quality of school health services. Program funds are expended to deliver services in the areas of greatest need to:

- Increase school nursing services;
- Improve and enhance the quality of school health services;
- Increase access to health care services for the uninsured and underinsured; and
- Provide health services where none were previously available.

During FY 2020-21, 57 school districts or BOCES contracted with the Department to receive Medicaid reimbursement for providing school health services to eligible clients. Other school districts, choosing not to contract with or bill the Department directly, participate in the program as a member of a BOCES. A BOCES is created when two or more school districts decide they have similar needs that can be met by a shared program. A BOCES may help school districts save money by providing opportunities to pool resources and share costs. As a result, school districts may receive Medicaid funds without having a direct contract with the Department, as the BOCES is the contracting entity and listed as the School Health Services Program Provider in this report. Further, school districts may bill directly for some services, such as transportation, while the BOCES provide and bill for the other services, such as direct services, on behalf of the school districts. In these cases, the number of school districts directly billing the School Health Services Program will vary each year and the program has no information as to how the Medicaid reimbursement is distributed from the BOCES to the school district.

Under the Department's approved Medicaid State Plan, all SHS Program Providers are required to participate in a quarterly random moment time study to determine the percentage of allowable time spent providing Medicaid claimable school health services. By utilizing a time study, providers receive a payment based on the actual cost incurred for providing Medicaid services, rather than through a fixed rate established by the Department.

- For FY 2019-20, 55 providers were reimbursed a total of $61,532,774 for direct services, Targeted Case Management (TCM), and Medicaid Administrative Claiming (MAC).

  During FY 2019-20 these funds were used to provide additional health services to all students in the participating districts. The most common areas that were funded statewide through the providers' LSPs were additional nursing services at $14,581,049; additional mental health services at $12,957,016; additional case

management services at $5,486,784; and additional health technicians/clinic aid hours at $3,813,928.

- For FY 2020-21, these providers have received interim payments in the amount of $39,606,977 for direct services and for three quarters of MAC payments a total of $5,609,158.

Prior to receiving a final payment based on the actual cost incurred for providing Medicaid services, SHS Program Providers submit claims and receive interim payments for providing services to eligible clients. After the fiscal year ends, each provider is required to complete a cost report documenting their total Medicaid allowable costs for delivering School Health Services and certifying their public expenditures. The cost report reconciles interim payments made to SHS Program Providers during the fiscal year against actual costs. If a provider's interim payments exceed the actual, certified costs of providing School Health Services, the provider must return the overpayment amount to the Department. If the provider's actual costs exceed the interim payments they received, then the Department pays the federal share difference to the provider. This cost reconciliation and settlement process is based on a cost allocation methodology approved by the Centers for Medicare and Medicaid Services (CMS). The cost reconciliation and settlement that most recently occurred was in FY 2020-21 for FY 2019-20.

In addition, the Department reimburses for administrative claiming to SHS Program Providers for the time spent in administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. MAC reimbursements are made quarterly through a claim that consists of payroll costs for staff that provide direct medical or health related services, administrative and outreach activities. As school staff work with students on a daily basis, they are uniquely positioned to assist in enrollment of eligible students in Medicaid, to assist them in receiving the medical services and supporting administrative and outreach services they require, and to provide medically necessary services. These administrative services form the basis for the MAC Program. MAC allowable activities include: facilitating Medicaid outreach, facilitating Medicaid eligibility determination, translation related to Medicaid services, medical program planning, policy development and interagency coordination, medical/Medicaid related professional development and training, referral, coordination and monitoring of Medicaid services.

As detailed in Table 1, for FY 2019-20 four quarters were eligible for MAC reimbursement, and 55 school districts participated in MAC for reimbursement totaling $6,269,784. In FY 2020-21, 57 SHS providers participated in MAC; reimbursements received totaled $5,609,158 for payments through the end of the third quarter.

Table 1 - Medicaid Administrative Claiming Net Payments

School Health Services Program Provider	FY 2019-20 Net Total MAC Payment	FY 2020-21 Net MAC Payments Three Quarters (July 2020-March 2021)
Adams 12 Five Star Schools	$732,089	$623,672
Adams Arapahoe SD #28J	$721,257	$631,538
Adams County SD #14	$95,871	$67,714
Alamosa SD RE-11J	$21,071	$12,166
Arapahoe County SD #2	$34,219	$23,909
Arapahoe County SD #6	$59,844	$56,882
Boulder County SD #2	$184,790	$144,166
Buena Vista SD R31	$8,506	$4,341
Cherry Creek 5	$386,531	$357,607
Colorado School for the Deaf and Blind	$47,950	$51,702
Colorado Springs SD 11	$77,384	$70,667
Counties of Adams & Weld SD 27J	$61,529	$54,996
Counties of Archuleta & Hinsdale District JT	$5,250	$4,363
County of Fremont RE-2 SD	N/A	$11,559
Delta County Joint SD 50J	$23,178	$18,602
Denver County SD 1	$999,194	$1,038,962
Douglas County SD 1	$251,467	$166,661
Eagle County RE50J SD	$24,527	$33,442
El Paso County SD #49	$172,844	$161,032
El Paso County SD #12	5355.71	$4,424
El Paso County SD #14	$16,747	$13,708
El Paso County SD #2	$66,374	$57,465
El Paso County SD #20	$43,548	$30,527
El Paso County SD #3	$81,438	$67,039
El Paso County SD #38	$10,164	$8,478
Englewood	$45,108	$41,049
Garfield County SD 16	$8,346	$9,958
Garfield County SD RE2	$11,996	$12,371
Gunnison Watershed SD	$3,105	$2,160
Jefferson County Public Schools	$298,646	$281,595
La Plata County SD #10JT-R	$3,944	$3,374
La Plata County SD #9-R	$16,251	$14,781
Lake County SD #10JT-R	$6,159	$5,967
Lamar SD RE2	$20,435	$17,470
Mapleton SD 1	$96,371	$79,641
Mesa County Valley SD 51	$380,866	$293,423
Montezuma Cortez	$8,812	$7,503
Montezuma County SD #RE-4A	$7,121	$7,149
Montrose County SD RE-1J	$17,141	$12,781
Otero County SD #1	$11,037	$8,322

School Health Services Program Provider	FY 2019-20 Net Total MAC Payment	FY 2020-21 Net MAC Payments Three Quarters (July 2020-March 2021)
Otero County SD #2	$3,410	$3,360
Park County RE2	$3,574	$4,217
Pikes Peak BOCES	$38,355	$35,320
Platte Canyon SD 1	$2,856	$1,395
Pueblo County SD #70	$115,931	$91,638
Pueblo SD #60	$270,173	$226,590
Rio Blanco BOCES	$5,970	$4,531
Roaring Fork SD	$85,477	$75,605
Salida SD R-32-J	$16,305	$20,216
San Luis Valley BOCES	N/A	$15,131
School District Fremont RE-1	$14,271	$15,191
St Vrain Valley RE 1J	$130,851	$126,837
Teller County SD #1	$5,275	$2,497
Thompson SD #2J	$169,341	$193,925
Weld County SD 6	$167,106	$145,186
Westminster SD	$155,622	$120,511
Woodland Park SD	$18,803	$13,839
Total	**$6,269,784**	**$5,609,158**

Not available (N/A) indicate that provider did not participate in the School Health Services Program at this time

Types of Health Services Delivered and Number of Children Served

Under the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and Title 22, C.R.S., public school districts are required to provide certain medical services for public school children. Additionally, school districts provide some level of health screening, nursing services and other medical support services for students. When delivered to a Medicaid enrolled student, some of these services qualify for Medicaid reimbursement.

SHS Program Providers can receive reimbursement from Medicaid for delivering services to Medicaid enrolled clients under the age of 21, as included in the Medicaid statute (Section 1905(a) of the Social Security Act) and as described in the Code of Colorado Regulations, 10 CCR 2505-10, Section 8.290. School Health Services may include direct services that are covered under the EPSDT benefit, including rehabilitative therapies; TCM and specialized non-emergency transportation services. SHS Program Providers must provide services that are medically necessary and provided to clients as prescribed in the

client's IEP, IFSP[2], or other medical plan of care where medical necessity has been established.

Under EPSDT[3], Medicaid must provide for screening, vision, hearing and dental services at intervals that meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. Additionally, under EPSDT, any service that Medicaid is permitted to cover under federal law that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to qualified clients regardless of whether the service or item is otherwise included under the Medicaid State Plan.

Rehabilitative therapies are those services which reduce a physical or mental disability, and which may improve physical or mental health levels. Rehabilitative therapies must be recommended by a physician or other licensed practitioner of the healing arts.

Specialized non-emergency transportation is reimbursable under Medicaid when provided on the same date of service that a Medicaid covered service required by the student's IEP or IFSP is received. Specialized Non-Emergency Transportation is provided to and from a student's place of residence and the school or the site of a Medicaid reimbursable service if the service is not provided at the school.

TCM services assist with accessing needed medical, social, educational, and other services for clients who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social, or physical development. Services may include individualized strengths and needs assessments; service planning that provides an individualized written, comprehensive service plan based on needs identified in the assessments; service coordination, monitoring and advocacy; and crisis assistance planning.

School districts received Medicaid reimbursement for providing medical services, TCM and specialized non-emergency transportation to 19,836 Medicaid enrolled clients in FY 2019-20 and 20,026 Medicaid enrolled clients in FY 2020-21. Table 2 summarizes the type of services for which districts received Medicaid reimbursement in FY 2019-20 and FY 2020-21 and the number of unique clients that received each service. It is important to note that as of FY 2020-21 57 providers participated in the SHS Program, accounting for over 83% of the total student population in the state of Colorado.

[2] The Individuals with Disabilities Education Act (IDEA), federal legislation on educating children with disabilities, defines how states and local education agencies are to meet their obligations to serve these students. The IEP and IFSP, required documents under IDEA, spell out the specific special education and related services, including health services, to be provided to meet the student's needs.

[3] The Omnibus Budget and Reconciliation Act of 1989 (OBRA'89) amended Sections 1902(a)(43) and 1905(a)(4)(B) and created Section 1905(r) of the Social Security Act setting forth the basic requirements of EPSDT.

Table 2 - Unique Clients Served by Medicaid Reimbursed Service

Medicaid Reimbursed Service	Unique Clients Served FY 2019-20	Unique Clients Served FY 2020-21
Speech, Language, and Hearing	15,110	16,139
Physical Therapy	1,509	1,359
Personal Care	4,879	3,737
Occupational Therapy	5,605	5,369
Orientation and Mobility	132	0*
Nursing	429	213
Psychology, Counseling, and Social Work	2,138	2,583
Transportation	2,713	2,090
Total Clients – All Services	**19,836**[4]	**20,026**[4]

*Starting in FY 2020-21 Orientation and Mobility services are captured along with Physical Therapy and Occupational Therapy services.

How Services Meet the Definition of Medical Necessity

School districts apply the Medicaid definition of medical necessity when identifying services for which they intend to claim reimbursement. The SHS Program defines a medically necessary service at 10 CCR 2505-10, Section 8.290.1, as a service that will, or is reasonably expected to:

> *…prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.*

Medical necessity is determined through the referral and authorization process. Where required by the Medicaid regulations, a qualified practitioner of the healing arts must refer a client for services. The client's IEP, IFSP, or other medical plan of care, when developed according to the Colorado Department of Education procedures, serve as an authorizing document. Technical assistance is provided for school district providers to identify those services delivered at schools that meet the definition of medical necessity. In addition, medical file reviews and quality assurance monitoring by the Department ensure that district providers comply with Medicaid requirements.

[4] Total Clients–Direct Services, Transportation, and Total-Clients All Services are unduplicated client counts in the respective category. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories. Unduplicated client counts presented in this table are based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Data Source: Medicaid paid claims from Colorado IBM Watson Health/TRUVEN Data warehouse. Financial Reporting & Analysis Unit, Department of Health Care Policy and Financing. September 14, 2020 for FY 2019-20 data and September 7, 2021 for FY 2020-21 data.

Federal Dollars Distribution to School Districts

As detailed in Table 3, during FY 2019-20, 55 SHS Program Providers received Medicaid reimbursement totaling $55,262,990 for direct service, Targeted Case Management and transportation. Additionally, as noted in Table 1, providers received $6,269,784 in MAC payments in FY 2019-20, and $5,609,158 in MAC payments for FY 2020-21 through three quarters – July 2020 – March 2021.

In FY 2020-21, claims submitted for Medicaid services by 57 SHS Program Providers resulted in interim payments and Medicaid reimbursement of $39,606,977 which were exclusively federal funds. As the original expenditure of the medical service was incurred by a public entity using local tax dollars or General Fund appropriated to educational institutions, the Medicaid reimbursement is federal funds.

In accordance with statute, the SHS Program can retain up to ten percent of the federal funds to cover the Department's and the Colorado Department of Education's administration costs. At the start of FY 2019-20 the Department was able to reduce the withhold to two and a half percent. In FY 2020-21, $1,597,669 was retained by the Department to cover administration costs. In addition, with the passing of HB 20-1385 and SB 21-213 to date the Department was able to retain $2,515,973 in FY 2019-20 and $6,037,313 in FY 2020-21 for general fund offset. These funds were a result of the increased federal matching percentage in conjunction to the Families First Coronavirus Response Act.

Table 3 - Net Medicaid Reimbursement to School Health Services Program Providers

School Health Services Program Provider	Total Net Medicaid Reimbursement for FY 2019-20	FY 2020-21 Net Medicaid Interim Payments
Adams 12 Five Star Schools	$3,941,646	$3,349,819
Adams Arapahoe SD #28J	$4,912,878	$4,243,627
Adams County SD #14	$801,536	$557,531
Alamosa School District RE-11J	$402,824	$227,656
Arapahoe County SD #2	$260,276	$146,000
Arapahoe County SD #6	$825,849	$585,188
Boulder County SD #2	$1,487,156	$1,319,228
Buena Vista SD R31	$100,378	$50,026
Cherry Creek 5	$4,473,011	$3,516,803
Colorado School for the Deaf and Blind	$180,729	$128,605
Colorado Springs SD 11	$1,458,978	$1,103,933
Counties of Adams & Weld SD 27J	$1,449,702	$851,807
Counties of Archuleta & Hinsdale District JT	$144,558	$91,523
County of Fremont RE2	N/A	$48,267

School Health Services Program Provider	Total Net Medicaid Reimbursement for FY 2019-20	FY 2020-21 Net Medicaid Interim Payments
Delta County Joint SD 50J	$316,161	$192,527
Denver County SD 1	$4,509,250	$3,448,072
Douglas County 1	$3,665,844	$2,535,971
Eagle County RE50J SD	$213,942	$59,716
El Paso Colorado School District 49	$1,693,754	$1,135,977
El Paso County SD #12	$188,121	$126,731
El Paso County SD #14	$236,895	$145,044
El Paso County SD #2	$668,128	$362,252
El Paso County SD #20	$1,390,966	$1,025,919
El Paso County SD #3	$354,216	$222,065
El Paso County SD #38	$208,508	$155,948
Englewood	$332,685	$223,696
Garfield County SD 16	$58,713	$50,304
Garfield County SD RE2	$284,386	$200,371
Gunnison Watershed SD	$88,258	$65,981
Jefferson County Public Schools	$4,804,243	$3,111,687
La Plata County SD #10JT-R	$140,647	$78,394
La Plata County SD #9-R	$290,722	$195,997
Lake County SD #10JT-R	$110,004	$61,873
Lamar SD RE2	$225,910	$145,636
Mapleton SD 1	$534,138	$347,102
Mesa County Valley SD 51	$2,533,712	$1,626,244
Montezuma Cortez	$153,140	$127,622
Montezuma County SD #RE-4A	$20,931	$16,903
Montrose County SD RE-1J	$490,319	$283,985
Otero County SD #1	$256,720	$170,186
Otero County SD #2	$77,990	$53,112
Park County RE2	$58,692	$45,019
Pikes Peak BOCES	$415,463	$293,341
Platte Canyon SD 1	$75,346	$36,883
Pueblo County SD #70	$1,329,422	$785,427
Pueblo SD #60	$1,664,301	$1,241,346
Rio Blanco BOCES	$55,315	$30,050
Roaring Fork SD	$267,582	$163,923
Salida SD R-32-J	$165,745	$118,421
San Luis Valley BOCES	N/A	$30,445
School District Fremont RE-1	$327,738	$141,030
St Vrain Valley RE 1J	$1,891,464	$1,400,664
Teller County SD #1	$65,346	$41,106
Thompson SD #2J	$1,224,814	$687,791

School Health Services Program Provider	Total Net Medicaid Reimbursement for FY 2019-20	FY 2020-21 Net Medicaid Interim Payments
Weld County SD 6	$1,793,467	$1,151,740
Westminster SD	$1,109,035	$753,065
Woodland Park SD	$531,439	$297,398
Grand Total	**$55,262,990**	**$39,606,977**

Not available (N/A) indicate that provider did not participate in the School Health Services Program at this time

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

April 5, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information.

The Department is requested to submit a report by April 1, 2021, discussing the appropriate role for the Department in resolving issues between behavioral health providers and payers, including the Regional Accountable Entities (RAEs), around billing, parity of coverage, and prior authorizations. The report should include a description of the tools available to resolve conflicts. The report should assess and discuss the administrative burden on providers, such as cumbersome prior authorization procedures or lack of timely adjudication of claims, and any other challenges with implementing the regional accountability entity structure. As part of the report, please provide a detailed description of who operates the RAEs in each region, how the operators are selected, and how the Department evaluates and prevents potential conflicts of interest. Also, please discuss differences in the performance of the RAEs in implementing the Substance Use Disorder benefit and how the policies of the RAEs are affecting implementation.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/LK

Enclosure(s): Health Care Policy and Financing FY 2021-22 Department RFI

CC: Representative Julie McCluskie, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Anne Saumur, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Role for the Department in Resolving Issues Between Behavioral Health Providers and Payers

In compliance with request dated March 18, 2021

April 5, 2021

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Request

The Department is requested to submit a report by April 1, 2021, discussing the appropriate role for the Department in resolving issues between behavioral health providers and payers, including the Regional Accountable Entities (RAEs), around billing, parity of coverage, and prior authorizations. The report should include a description of the tools available to resolve conflicts. The report should assess and discuss the administrative burden on providers, such as cumbersome prior authorization procedures or lack of timely adjudication of claims, and any other challenges with implementing the regional accountability entity structure. As part of the report, please provide a detailed description of who operates the RAEs in each region, how the operators are selected, and how the Department evaluates and prevents potential conflicts of interest. Also, please discuss differences in the performance of the RAEs in implementing the Substance Use Disorder benefit and how the policies of the RAEs are affecting implementation.

II. Introduction

The Department of Health Care Policy and Financing (Department) is aware that stakeholders have expressed a variety of concerns regarding the Department's administration of the capitated behavioral health benefit. The Department appreciates this opportunity to provide information about how the Department has been addressing these issues and its strategies for the future.

The Department is committed to providing Medicaid members access to a full continuum of behavioral health services. For over 20 years, the Department has collaborated with the State General Assembly and behavioral health providers to design and implement a robust behavioral health benefit package that is unmatched by any other health plan in the State. The full continuum of behavioral health services is only made possible under a managed care arrangement with the federal government. The Department's managed care arrangement allows for coverage of services that are not available under federal fee-for-service guidelines. These are non-traditional, community-based alternative services such as peer recovery services, respite care, clubhouse and drop-in centers, intensive case management, short-term inpatient stays in Institutions for Mental Diseases (IMDs) and other services essential for supporting recovery of individuals with serious mental illness. Managed care

arrangements also enable the Department to gain access to clinical expertise and provide a mechanism to provide predictable and stable funding to safety net providers.

In collaboration with stakeholders, Colorado is tackling large-scale behavioral health reform to improve services. Within Medicaid, this includes continued improvements in integrated physical and behavioral health under the Regional Accountable Entities (RAEs), the implementation of the Prescriber Tool that includes Opisafe – an addiction reduction and prevention tool, creating the plan to transition to Qualified Residential Treatment Programs to align with the implementation of the Family First Prevention Services Act, and the implementation of a new federal waiver to provide coverage for residential and inpatient substance use disorder (SUD) services.

More broadly, the recent Behavioral Health Task Force, which we are actively leading along with the Colorado Department of Human Services, has recommended sweeping changes to the Colorado behavioral health care system going forward. The Task Force recommendations, outlined in the Blueprint for Behavioral Health Reform, along with legislative directives from Senate Bill 19-222 Individual At Risk for Institutionalization, will result in other upcoming changes to improve the state's behavioral health system, increasing access and better support for our members. The Department is working on the following efforts:

- We are in the process of drafting a gap analysis of the behavioral health providers and facilities by RAE region and will be creating regional plans and incentives with each RAE to fill in any gaps to increase contracting with behavioral health providers for FY 21-22.
- The Department is preparing an analysis of outpatient behavioral health rates across Medicaid, Medicare, and commercial payers, and how they impact the workforce. This will be published in Summer 2021 and will influence the behavioral health reform efforts across all state agencies. The report will be completed and posted by July or August 2021, and shared with stakeholders through the Beahvioral Health Reform Workgroup and Executive Committee.
- In accordance with SB 19-222, the Department is working with the Department of Human Services to deliver a comprehensive proposal to

strengthen and expand the behavioral health safety net system in Colorado. This includes new standards for providers, more support for wrap around and comprehensive services, and an updated value based payment model. This report is due to the General Assembly by July 1, 2021. We have hired a vendor to ensure that the value based model will work within and improve the managed care system for behavioral health. This model, per statute will be operational no later than July 2024.

Concurrent with all of this work, the Department is actively focused on getting Coloradans covered during this economic downturn while also driving vaccination uptake in our membership which will open up the economy, increase jobs and allow members to exit this year of isolation. All these strategic initiatives have a common goal of helping improve behavioral health care delivery, outcomes, and access.

While changes to improve access, prevent addiction, improve care delivery and enhance integration have widespread public support and will bring positive change to the Colorado behavioral health system and to Medicaid members, all of these initiatives represent change and disruption to the status quo. Some of these changes are also difficult to implement. And as with any new policy or program, it often takes time to learn where and how to improve operations and it take time for stakeholders – our providers, our members, our partners (i.e.: RAEs) - to adjust, accommodate and adapt to the number of changes that are in process.

The Department strives to be flexible and has best-practices to manage these new initiatives. First, the Department uses the available, often limited, information to design and set clear performance outcomes for the RAEs and for our providers. Prior to and during implementation of any change, the Department and its vendors actively educate and prepare providers, members, and other stakeholders for the new model of care. Once implemented, the Department closely monitors the system, making any immediate changes necessary while also allowing the system time to evolve, adapt and adjust. This step is followed by resetting outcome targets based on emerging information and leveraging additional tools to support the system in achieving the new goals. Due to the newness of the inpatient and residential SUD benefit and the Prescriber Tool, the Department is in the midst of steps one and two above.

As stated earlier, the Department is aware of a variety of concerns among stakeholders. The Department is committed to maximizing and reallocating available resources to address concerns as they surface and to increase supports to providers to help them adjust to new programs and policies. The Department is currently using a variety of methods to address the concerns brought to our attention:

- Actively research and intervene on complaints that come to the Department, including reaching out to the RAEs and facilitating resolutions with our provider partners.
- Increasing stakeholder engagement activities.
- Identifying and pursuing opportunities to standardize processes among RAEs.
- Leveraging our Department contracts to hold RAEs accountable.
- Enhancing training, standardization and transparency.

III. Department Role and Tools for Resolving Conflicts

The Department takes an active role in investigating and resolving complaints that are brought to its attention. To work through issues, the Department uses all of the tools available, from relationships with the RAEs and providers, to formal performance assurance levers available under the RAE contract.

Most of the recent complaints center around utilization management processes, contracting and reimbursement rates. In an effort to be more effective in addressing the different issues that have arisen recently, the Department has categorized issues into three general classifications:

- Challenges and/or inconsistencies across RAE practices.
- Lack of knowledge or experience with standard managed care practices, federal requirements and payment reform practices.
- Lack of familiarity with Medicaid requirements and standard practices.

A. Challenges and/or inconsistencies in RAE practices

In analyzing the complaints received, there are times when the RAEs are not complying with their contract or their own policies and procedures regarding items such as claims processing, prior authorizations, and contracting. In these instances, the Department plays a very active role.

The Department's role whenever a concern is brought to the Department's attention is to investigate it. This usually begins by talking with the RAE to understand what is happening or what has happened. The Department then askes the RAE to contact the provider to address the specific issue. If a provider does not feel the situation is appropriately addressed, the Department will host a joint meeting between the provider, the Department and the RAE to facilitate a resolution.

When an issue is significant or has not been properly resolved through informal means, the Department leverages formal tools within the contract to escalate the issue. These contract tools range from official warning letters and monitoring plans, to formal Corrective Actions, and can ultimately include termination for breach of contract. There have been several examples recently when the Department has placed RAEs on monitoring plans or under Corrective Action for problems that were not addressed satisfactorily.

During the investigation of an issue, there are times when the issue is rooted in variation or inconsistencies across the RAEs. While variation is a natural part of managed care and the Department's regional model, at times it can become a significant challenge or barrier for providers and/or members. In these instances, the Department takes an active role in driving appropriate standardization across the RAEs.

Recently, the Department has found that the most effective method for addressing systemic issues and establishing standardization is to create targeted forums between Department staff, the RAEs and the specific provider group that has expressed challenges. The Department successfully used this strategy to resolve a number of issues with the IMDs and has ongoing forums with hospital providers and child welfare agencies (See the fact sheet Accountable Care Collaborative: Role of Freestanding Psychiatric Hospitals and the Federal IMD Rule for more information). Resolutions can take the form of documented processes and procedures, memorandums of understanding, or amendments to the RAE contract.

The Department is in the process of establishing a forum with residential and inpatient SUD providers to more effectively collaborate on resolving

the various issues arising from implementation of the new benefit, including use of national standards for placement and how to braid funding from more flexible state sources, like the Office of Behavioral Health's block grant benefits.

B. Lack of knowledge or experience with standard managed care practices, federal requirements and payment reform practices

As stated in our introduction, managed care provides many benefits to the State. These benefits range from the extended array of behavioral health services, to enhanced assurances regarding member access to care and choice of provider, to accountability for outcomes. And this work is conducted in a way that is fiscally responsible, which allows the state to afford a greater continuum of benefits to Medicaid members to meet the increasing demands for behavioral health services.

As with any managed care program, the RAEs are responsible for contracting with a network of high-quality providers and employing utilization management to ensure services are medically necessary, that the services are achieving the intended outcomes and that financial resources are being used wisely. The RAEs, along with every commercial health plan, rely on evidence-based practices and published best practices to determine the appropriateness of services. For some providers, these practices may be unfamiliar or appear burdensome.

As Medicaid is a unique federal-state partnership intended to serve underserved and disabled individuals, the federal government has established additional rules to prevent managed care organizations from limiting access to care or benefitting from perverse incentive arrangements that may be present in a managed care arrangement. Many of these federal requirements are not found in commercial managed care arrangements, including provider choice protections, prohibitions against provider discrimination, member communication requirements, processes for handling grievances and appeals, timeliness for claims processing, and timelines and standards for authorization decisions and noticing of adverse benefit determinations. In particular for providers new to Medicaid under our SUD benefit, it can take time to adapt to these new Medicaid norms. Still, these protections have been developed in collaboration with the

public; many of these federal administrative checks and balance are designed to offer greater accountability, transparency and safeguards for both members and providers.

A number of the recent complaints are based on a misunderstanding of managed care or expectations that conflict with the core principles of managed care that help ensure the delivery of appropriate, quality care. There is particular confusion about the requirements placed on Medicaid managed care entities, and what the Department is allowed to direct and not direct the RAEs to do. Under a managed care arrangement, the responsibility for the program is shared between the Department and RAEs, with certain responsibilities primarily with one or the other party. The Department contracts with the RAEs to be administratively responsible for the capitated behavioral health benefit. This includes processing all authorization requests and claims. The Department's role is to provide oversight and ensure the RAEs comply with its contract as well as state and federal regulations. The Department ensures that the RAEs comply with the thorough federal requirements around adverse benefit determination notifications and the processing of grievances and appeals. The Department also receives encounter reporting information from the RAEs, which is housed in its data repository and is used to create insights on how the behavioral health program is operating. RAE contracted behavioral health providers are also enrolled in our Medicaid provider systems to enable access comparisons and the like.

The Department and the RAEs have been taking a number of actions to help providers and stakeholders better understand how the RAEs and a Medicaid managed care program function to improve process transparency, set expectations, and reduce challenges.

- The RAEs educate providers about their managed care practices and assist providers in complying with the practices. Strategies include trainings and webinars on different processes and procedures, toolkits, standard meetings with providers, hands-on technical assistance for individual practices around contracting and utilization management

practices, and participation in joint education efforts with the Department.

- The Department has participated in technical assistance and ongoing forums with different provider groups to clarify the different roles and responsibilities. In addition, the Department has contracted with a vendor to create a Medicaid managed care educational campaign to include fact sheets, presentation slides and other materials the Department can use with a variety of audiences to better understand roles and responsibilities and the benefits and flexibilities that exist in managed care that are not available in a fee for service system.

Another area of significant confusion is regarding Mental Health and Substance Use Disorder Parity (Parity). There is a common impression that Parity requires that access to services and reimbursement be equal, and that any use of utilization management is a violation of parity. However, parity regulations are focused on whether processes are comparable to and applied no more stringently within broad classifications of inpatient, outpatient, prescription drugs, and emergency care. The Department conducts a comprehensive assessment of compliance with Parity at least one time annually; these assessments have been approved by the Centers for Medicare and Medicaid Services (CMS). This year, in order to address these areas of confusion and evaluate the Department's processes for monitoring Parity, the Department has contracted with an external vendor to:

- Provide a written assessment of the Department's annual Parity report and whether the Department followed standard practices.
- Host an educational webinar describing parity and provide other documented materials.

C. Lack of familiarity with Medicaid requirements and practices

As the Department investigates different issues to determine whether it is a RAE management issue or a lack of understanding, it sometimes becomes apparent that a provider does not have a defensible complaint but is instead just expressing their grievance against the system. For example, substance use disorder residential programs may prefer to have an established length of stay for all clients. However, Medicaid is required to

use evidence-based clinical criteria to make length-of-stay determinations. Predetermined lengths of stay also do not align with the Department's principle for serving members in the least restrictive environment.

The Department acknowledges that public funding does require following complex rules that are not often included in commercial health plans and may be different for those SUD providers who are new to the Medicaid system. However, and as stated previously, these requirements have been established to protect both members and providers, to ensure services are most likely to meet a member's health needs, and to ensure the Department can manage the benefit appropriately.

In these instances, the Department uses all of the strategies referenced previously, from working directly with a provider and RAE, to providing additional and targeted education about Medicaid managed care rules and processes. It is sometimes challenging, but important, for the Department and other stakeholders to do the due diligence to determine whether a provider is presenting information accurately and completely instead of promoting changes that support a business model but do not align with state and federal regulations.

IV. Implementation of New Substance Use Disorder Services

The request by the General Assembly asked for information regarding the Department's implementation of the new residential and inpatient SUD benefit. As of the end of March, the RAEs have contracted with 30 unique providers across 48 locations. These contracts cover 1,352 SUD specific beds, representing 53% of the beds available at the time and 65% of the unique provider locations. The number of members in treatment across all American Society of Addiction Medicine (ASAM) levels of care has been increasing each week from 189 members during the first week of January to 300 members during the week ending March 26, 2021.

It is too early in implementation for the Department to provide any accurate assessment of the new services or the RAEs' management of the program. Given the SUD program is only three months old, and it takes time for providers to submit claims for reimbursement and the RAEs to process and report those

payments to the Department, the Department is just beginning to receive initial encounter data.

Given the delays in official reporting of encounter data, the Department has been manually collecting weekly data from the RAEs regarding members in treatment, estimated weekly costs, numbers of denials, average lengths of stay, and other critical data points. The Department is actively monitoring this data to ensure access is continuing to increase while providers and the RAEs improve utilization management processes. The transition to Medicaid reimbursement for these services required providers and the RAEs to learn and adopt a variety of new processes and procedures.

The Department has already implemented a number of activities to support providers and improve implementation, including:

- Regularly scheduled technical assistance between Department staff, RAEs, and SUD providers to address identified issues.
- The Department has instructed the RAEs to use a peer review process with the SUD providers after every denial so providers better understand the reason for the denial.
- The Department directed the RAEs to work collaboratively to establish initial authorization length of stay standards for different levels of care to reduce the burden on providers.
- RAEs are establishing processes so that SUD providers that are not able to accept a new member because their beds are full can assess the member and refer the member to the RAE to help with placement or to provide wraparound services until a bed becomes available.
- The Department has contracted with an SUD clinician and consultant to serve as a liaison between the Department and SUD providers, particularly around improving utilization of the American Society of Addiction Medicine level of care criteria.

At the same time, the Department is planning a number of actions to improve implementation in the future. These actions include:

- Utilizing available data to create a plan for the RAEs for next fiscal year to correct and close the gap between current performance and the Department expectations regarding access to services.
- Implementing additional training for providers and the RAEs on utilization management and the American Society of Addiction Medicine level of care criteria.
- Implementing the American Society of Addiction Medicine Continuum computerized decision support system to improve consistency of the application of level of care criteria among the RAEs and SUD providers.

The Department will continue to monitor implementation and new data as it becomes available to identify additional strategies that need to be used to improve implementation of these essential new services.

V. Regional Accountable Entities

The General Assembly also requested information about the selection of the RAEs, the ownership of the RAEs, and the Department's management of conflicts of interest.

The Department conducted a formal procurement process in 2017 using a request for proposals (RFP), in accordance with state procurement rules. The Department published a draft of the RFP for public comment and revised the final RFP based on feedback received.

To ensure the chosen vendors met the needs of the broader community and to prevent a conflict of interest in the choice of vendor, the Department included representatives from the stakeholder community in the selection process. Community members were chosen who did not have a conflict of interest or bias in the outcome, but who had significant knowledge of the Medicaid system. A group of community representatives and Department staff not involved in the design and creation of the RFP conducted an impartial review of all proposals and selected the final RAE contractors that were determined to be most advantageous to the State. Figure 1 identifies each RAE Region and Table 1 provides the name and legal partners of each RAE.

Figure 1. Map of Accountable Care Collaborative Regions

Table 1. Regional Accountable Entities by Region

Region	RAE Name	Legal Partners/Owners
1	Rocky Mountain Health Plans	• Rocky Mountain Health Plans (a subsidiary of United Healthcare)
2	Northeast Health Partners	• Centennial Mental Health Center • North Range Behavioral Health • Salud Family Health Centers • Sunrise Community Health
3 & 5	Colorado Access	• Colorado Access

Region	RAE Name	Legal Partners/Owners
4	Health Colorado, Inc.	• Beacon Health Options • Health Solutions • San Luis Valley Behavioral Health Group • Solvista Health • Southeast Health Group • Valley-Wide Health Systems
6 & 7	Colorado Community Health Alliance	• Anthem, Inc. • Centura Ventures, LLC • Physician Health Partners, LLC • Primary Physician Partners, LLC
Denver Health	Denver Health Medicaid Choice	• Denver Health Medical Plan (a subsidiary of Denver Health and Hospital Authority)

The Department was invested in retaining a regional model and leveraging the strengths of both local, community-based vendors with national vendors to continue to evolve the program.

Lastly, within the RAE contract, the Department included requirements to encourage transparency around conflicts of interest. This includes annual disclosures of ownership and control interests in the RAE, public posting of each RAE's governing body, and the creation of a RAE Governance Plan that describes how the RAE will protect against any perceived conflict of interest.

VI. Conclusion

The Department appreciates this opportunity to describe how it takes complaints from providers, members and other stakeholders extremely seriously. This document attempts to convey both the traditional tools the Department uses to manage the Accountable Care Collaborative, while

describing the Department's recent and planned strategies to escalate and expedite resolution to a number of current community concerns. It also underscores the unique and dynamic time we are in, including an increase in behavioral demand due to the COVID impact, the implementation of the SUD benefit, the implementation of the Prescriber Tool and the management of the federal Families First Prevention Services Act. We are actively partnering across Departments, providers and our contractors to maximize the behavioral health opportunities and to address systemic challenges.

COLORADO
Department of Health Care Policy & Financing

School of Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

October 1, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the response to the Joint Budget Committee's Request for Information for Multiple Departments #4 regarding the Department of Health Care Policy and Financing (the Department) and the University of Colorado.

Request for information #4 states:

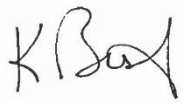
Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1, 2021.

The report includes information on the supplemental payment methodology/structure, the amount of funds disbursed during State Fiscal Year (SFY) 2020-21, an overview of the work completed during the fourth year of the program, and inherent benefits supporting continuation of the program.

This report pertains specifically to the Supplemental Payment to the University of Colorado School of Medicine for Physician and Professional Services.

If you require further information or have additional questions, please contact the Department's Legislative Analyst, Iris Hentze at iris.hentze@state.co.us.

Sincerely,

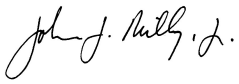


Kim Bimestefer
Executive Director
Department of Health Care Policy and Financing

Sincerely,

Todd Saliman
President
University of Colorado System

Sincerely,



Dr. John J. Reilly, Jr.
Vice Chancellor for Health Affairs
University of Colorado Anschutz Medical Campus

KB/DV

Enclosure(s): Health Care Policy and Financing FY 2020-21 Multi-Department RFI #4

CC:

Representative Julie McCluskie, Vice-chair Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
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Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, Deputy Director, Policy Communications & Administration Office, HCPF
Brian T. Smith, Sr. Associate Dean, University of Colorado School of Medicine/Executive Director, University of Colorado Medicine
Terri Carrothers, Executive Vice Chancellor for Administration and Finance, University of Colorado Anschutz Chief Financial Officer

Legislative Request for Information 4

Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1, 2021.

Executive Summary

This report is presented to the Joint Budget Committee (JBC) of the Colorado General Assembly in response to Legislative Request for Information 4. Legislative Request for Information 4 requests the following:

- Information About This Program's Various Public Benefits

  Within the capacity of the supplemental payment program to the University of Colorado School of Medicine (CUSOM), CUSOM will maintain and increase access to specialty care for Health First Colorado members around the state, as well as deliver comprehensive primary care in the Denver metropolitan area. Public benefits in State Fiscal Year (SFY) 2020-21 include: support for development of an e-consult program; investment in technology that promotes the virtual share of knowledge and experience to manage complex health issues; improved access to specialty care and behavioral health services, including substance use disorder treatment; improved health care access in rural and frontier areas; expansion of telemedicine services; and supplemental payments to providers for direct clinical care.

Background Information

The Colorado Department of Health Care Policy and Financing (the Department) submitted an initial State Plan Amendment (SPA) 16-0006 on September 30, 2016 to the Centers for Medicare & Medicaid Services (CMS) for a supplemental payment for physician and professional services delivered by providers employed by a public medical school. CMS approved the SPA on July 13, 2017, allowing the University of Colorado School of Medicine (CUSOM) and the Department to enter into a partnership to improve access to primary and specialty care for Health First Colorado members. To memorialize the partnership and to establish expectations, the Department and CUSOM jointly developed an Interagency Agreement (IA) by engaging the community to identify high priority areas of focus designed to achieve the intended improvements in access; as well as to improve quality and outcomes for Health First Colorado members. Annually, the IA and SPA are updated as a collaboration between the Department and CUSOM.

Supplemental Payment Methodology/Structure

Per federal regulations, aggregate Medicaid payments to groups of providers are allowed up to the amount of an Upper Payment Limit (UPL). The UPL is the difference between a reasonable estimate of what commercial payors utilizing Medicare payment principles would have paid for professional services delivered to Health First Colorado members and what was actually paid by Health First Colorado. As such, supplemental payments to CUSOM for Physician and Professional Services to Health First Colorado members are made quarterly based on periods of service from a year prior. For example, a supplemental payment made by the end of the State Fiscal Year (SFY) 2019-20 first quarter (July 01, 2019 - September 30, 2019) is based on services provided to Health First Colorado members during the SFY 2018-19 first quarter (July 01, 2018 – September 30, 2018).

Since the Department is the only authorized agency to draw down federal Medicaid funds, both General Funds originally designated to CU Anschutz and CU Medicine clinical revenue is transferred to the Department on a quarterly basis. Once federal funds are drawn then payments are made directly to CUSOM (via University Physicians, Inc, dba University of Colorado Medicine.) which includes the matching federal Medicaid funds. Table 1 below shows the General Fund originally designated to CU Anschutz, CU Medicine clinical revenue, and drawn federal funds for each supplemental payment paid to CUSOM during SFY 2020-21.

Table 1 – Schedule of Supplemental Payments to CUSOM
SFY 2020-21

Period of Payment	Total Fund	Reappropriated Fund	Cash Fund	Federal Fund	Date of Service FMAP	FMAP
QE-09/30/20	$37,947,818.50	$7,426,653.00	$11,547,256.25	$18,973,909.25	QE-09/30/19	50.00%
QE-12/31/20	$37,947,818.50	$7,426,653.00	$11,547,256.25	$18,973,909.25	QE-12/31/19	50.00%
QE-03/30/21	$43,319,428.00	$7,426,653.00	$11,547,256.25	$24,345,518.75	QE-03/30/20	56.20%
QE-06/30/21	$43,319,428.00	$7,426,653.00	$11,547,256.25	$24,345,518.75	QE-06/30/20	56.20%
Total	**$162,534,493.00**	**$29,706,612.00**	**$46,189,025.00**	**$86,638,856.00**	**N/A**	**N/A**

At any time, this program is subject to review by the U.S. Department of Health and Human Services (DHHS), CMS for timely filing of claims and conformance to the reimbursement methodology and other stipulations outlined in the Medicaid State Plan, Supplement to Attachment 4.19B - CUSOM Supplemental Payments for Physician and Professional Services. Documentation from either CUSOM or the Department, including but not limited to demonstrations that this program is qualified to receive reimbursement, may be requested by CMS, the Office of Inspector General (OIG), or the Office of the State Auditor (OSA), and both CUSOM and the Department are responsible for providing that documentation promptly. In the event that the Department determines that this program's reimbursement payments were made in error, or in the event of a disallowance of federal funds by CMS, CUSOM must return the appropriate amount of funds.

Interagency Agreement

The Department and CUSOM mutually agreed upon an Amendment to the IA for SFY 2020-21. The SFY 2020-21 IA outlines categories and amounts for funding which align with the priorities and Deliverables of the agreement. Table 2 below shows the allocation of funds as stipulated in the IA. Please note, this table excludes carryforward funds from the previous fiscal year.

Table 2 - Allocation of Program Funds
SFY 2020-21

Program Initiatives	SFY21 Allocation of Funds
Maintain & Expand Medicaid Member Volume	45.56%
Expand Access & Enhance Care Using Evidence-Based Health Care Delivery Models	27.18%
Expand Targeted Rural Patient Access	8.31%
Expand Telehealth	3.92%
Improving Transition of Care and Patient Follow-up	1.73%
Support for Federally Qualified Health Centers (FQHCs)	3.17%
Farley Health Policy Center	0.58%
Support for Rural and Diversity Programs	1.15%
Collaborative Initiative Funding	8.39%
Total	**100.00%**

For SFY 2020-21, a portion of the federally matched funds were tied to deliverables under areas of priority focus selected in collaboration between CUSOM and the Department in order to track the program's success in increasing public benefit. As funding levels cannot be altered during the current state fiscal year, performance will impact the amount of funding requested in the following state fiscal year's SPA submitted to CMS. As currently in the IA, CUSOM will receive 100% of the JBC appropriated amount if 100% of the performance measures are met. If less than 100% of the performance measures are met, then CUSOM will receive the SFY 2021-22 maximum less applicable performance-based portion of federally funded monies. The performance-based portion will account for 10% of the federally matched funding, with each of the performance measures equally accounting for 2%. Please note, that the 2% is tiered. If 90% of the measure is achieved, then only 10% of the funds as part of that two percent are withheld from CUSOM.

As such, the total amount of at-risk federal funds for SFY 2021-22 based on the SFY 2020-21 priority area deliverables is $8,663,886.

SFY 2020-21 Priority Areas

Table 3 below shows the five priority areas jointly agreed upon by the Department and CUSOM to be achieved by the end of SFY 2020-21. CUSOM and the Department enhanced focus in SFY

2020-21 towards strategic planning, program development, community engagement, and building a strong evaluation protocol.

Table 3 – IA Priority Areas
SFY 2020-21

#	Priority Area	Goal	Deliverable	Status
1	Evaluation and Process Improvement	In partnership with the Department, demonstrate continuous evaluation of projects supported by supplemental funding to ensure projects are meeting their intended objectives and align with overarching program goals.	Strategy meeting to occur six months into fiscal year to review best practices, challenges, and strategic vision moving forward for project deliverable success.	COMPLETE
2	Specialty Care Action Plan	Completion of Deliverables outlined in Specialty Care Action plan for Urology, Rheumatology and Dermatology.	Three clearly defined Problem Statements, SMART goals, Key Driver Fishbone Diagram outlining root cause analysis outcomes, and Quarterly Report on progress.	COMPLETE
3	Community Engagement	Engage and consult with the community through ongoing stakeholder meetings, development of a community feedback process, and by increasing transparency through informational materials outlining Interagency Agreement outcomes and activity.	Development of community facing material and minimum of two community presentations.	COMPLETE
4	eConsults	Continued adoption and further interoperability enhancement of eConsult activity with FQHC partners to include ongoing eConsult user feedback on challenges, barriers, areas for improvement and successes in order to integrate into performance improvement activities and ongoing refinement of eConsult workflows. Partnership with the Department to inform eConsult best practice and policy development.	Cost Savings Analysis and Quarterly Reporting measures.	COMPLETE
5	ECHO (Extension for Community Health Outcomes)	Continuation and enhancement of ECHO series in partnership with community and governmental organizations to promote peer learning opportunities, knowledge exchange, and collaboration.	Presentation of ECHO program to the Department and Year End Reporting measures.	COMPLETE

Completion status of these priority area deliverables determines the amount of discount applied to the following state fiscal years' allowable level of funding. Based on Table 3 above, CUSOM qualifies to receive the entire $8,663,886 at risk federal funds in SFY 2021-22.

Expenditure and Carryforward Report

Aligned by IA categories, Table 4 below shows the SFY 2020-21 IA budget, expenditures, and carryforward balance.

Table 4 – Expenditure and Carryforward Report [(1)]
SFY 2020-21

IA Section	SFY21 IA Allocations	SFY21 Funds Spent	Obligated SFY21 Carryforward Funds
5.1 Expand Medicaid Member Volumes	$39,471,298	$39,469,035	$2,263
5.2 Expand Access and Enhance Care Using Evidence-Based Health Care Delivery Models	$23,550,000	$16,829,049	$6,720,951
5.3 Expand Targeted Rural Patient Access	$7,200,000	$4,336,713	$2,863,287
5.4 Expand Telehealth	$3,400,000	$1,991,846	$1,408,154
5.5 Improving Transition of Care and Patient Follow Up	$1,500,000	$1,058,164	$441,836
5.6 Support for Federally Qualified Health Centers (FQHCs)	$2,750,000	$532,221	$2,217,779
5.7 Farley Health Policy Center	$500,000	$479,523	$20,477
5.8 Support for Rural and Diversity Programs	$1,000,000	$2,030,000	($1,030,000)
5.9 Collaborative Initiative Funding	$7,267,558	$5,864,403	$1,403,155
Total	**$86,638,856**	**$72,590,954**	**$14,047,902**

[(1)] A detailed project-level SFY 2020-21 Expenditure Report is included in Appendix A

Table 5 below shows the SFY 2020-21 carryforward funds from Table 4 and prior year carryforward funds which have been obligated toward strategic program investments.

Table 5 – Carryforward and Obligated Targeted Investments
SFY 2020-21

Description	Amount
SFY21 Carryforward Funds	$14,047,902
Obligated Targeted Investments	$89,638,624
Total	**$103,686,526**

SFY 2020-21 Carryforward

Mostly due to remaining restrictions on hiring new staff to support funded projects and delayed project ramp-up during the lingering COVID-19 pandemic, approximately 16% of the allocated funding was unspent in SFY 2020-21. The unspent carryforward funds outlined in Table 5 have been allocated to the following future program commitments:

- $5 million of the SFY 2020-21 carryforward funds will be used to sustain the 12% increase in Health First Colorado member volumes seen in SFY 2020-21.
- Approximately $7 million will be earmarked to pay for additional staffing costs for the current and future delivery of the programs supported by this funding.
- Approximately $2 million will be used to support expansion of current projects that are exemplary in their work to expand access to Medicaid members, in addition to potential new investments identified jointly by CUSOM and the Department.

Obligated Targeted Investments

Certain programs being developed through this supplemental funding require a multi-year funding obligation. These multi-year obligations are critical to not only carrying out the objectives of the IA, but also expanding access and improving the quality of care to Health First Colorado members. The obligated targeted investment funds outlined in Table 5 include the following program commitments:

<u>$25 million - Aurora Community Health Commons Federally Qualified Health Center (FQHC) and Residency Program</u>

The Aurora Community Health Commons (ACHC) and Residency Program represents a joint commitment by CUSOM and Salud Family Health Centers to promote health and access to medical services as well as interdisciplinary training programs for the approximately 48,000 people in ZIP codes 80010, 80011, and 80012 that currently do not have access to a primary care provider. This 5-year investment will secure funding for the new facility being planned at the corner of Airport Road and Colfax Avenue in Aurora. It will also provide the financial commitment necessary to achieve accreditation for 3 years of a General Internal Medicine/Family Medicine interdisciplinary residency training program. These individuals will provide access to quality medical services to vulnerable Coloradans. Experience has demonstrated the value of training

programs in under-resourced communities for building a diverse workforce that is more likely to remain in the community after completion of their training program.

$10 million - Center for Health Equity

The Center for Health Equity is a program dedicated to research, community engagement, education, and breaking down health and health care silos and barriers. The COVID-19 pandemic illustrates the need for investment in researching the impact of diseases and need for action on health equity issues. This will put Colorado at the forefront of research on how communities of color are being impacted in a disproportionate way. This 5-year funding commitment will support the work of health care providers to partner with the community and take steps to ensure opportunity, health, and well-being are justly distributed, available, and accessible. The Center will be located in the heart of the ACHC and will have long-lasting beneficial effects on the quality of life and access to care for under-resourced populations at local, statewide and national levels.

$35 million - Medicaid Enhanced Clinical Provider Payments

Recruitment and retention of high-quality providers is a key pillar of the CUSOM strategy to ensure access to care for traditionally under-resourced populations. Supplemental funding payments to providers at CUSOM are directly tied to Health First Colorado clinical activity. These funds will enable our providers to serve more Health First Colorado members, increasing access to primary care and specialty services for the Health First Colorado population. These payments are necessary to maintain and increase access to services for Health First Colorado populations throughout the state of Colorado. As the supplemental funding program pays providers one year in arrears, this funding commitment will provide an obligated year payment committed to providers if this program's funding is substantially decreased or discontinued.

$10 million - Diversity Scholarships

As part of our commitment to ensure that providers represent and understand the communities that they serve, CUSOM provides full and part tuition scholarships for students with backgrounds that are underrepresented in medicine. CUSOM has developed programs that bring students from all backgrounds to our campus to cultivate an interest and expertise in health care professions beginning in the public schools and through their undergraduate education. These students are highly sought after by prestigious medical schools across the country. Supplemental funding dollars have provided the scholarship support necessary for CUSOM to be competitive in recruiting these well-trained and highly qualified candidates. The commitment to these students extends throughout their 4 years of medical education. Data demonstrate that candidates with diverse backgrounds and experiences are more likely to choose primary care specialties and continue work in these communities after residency training.

$9.6 million - Program Specific Decommissioning

Should this program's funding be discontinued or significantly cut via actions taken at either the state or federal level, $9,638,624 is obligated to thoughtfully discontinue currently funded

programs. Special consideration will be given to programs that are identified to be essential to protecting Health First Colorado member care and to ensure there is no "cliff effect" that occurs.

SFY 2020-21 Work Completed

During SFY 2020-21, CUSOM and the Department entered their fourth year of partnership to increase the support of Health First Colorado members across the state via supplemental payment funding.

CUSOM providers saw a total of 150,652 unique Health First Colorado members across all 64 counties in Colorado, representing a 12% increase over SFY 2019-20 volumes (134,221) and a 23.5% increase from SFY 2016-17 baseline (122,009).[1] CUSOM provided 63,944 primary care medical home visits to Health First Colorado members during SFY 2020-21 across 17 primary care access sites. COVID-19 provided an impetus to quickly ramp up scheduled and on-demand telehealth capacity for Health First Colorado members across Colorado who would otherwise have avoided care or traveled long distances to receive specialty care. With a 120% increase from SFY 2019-20 telemedicine volume, 40,007 telemedicine visits occurred in SFY 2020-21.

The supplemental payment program supports the health care workforce through full-time equivalent (FTE) support for high-need clinical providers, data and analytics support, and operational staff. The program supports a total of 601 individuals for 246.56 total FTE, inclusive of staff supported at partnering organizations.

<u>Key Program Successes in SFY 2020-21:</u>

- Developed Specialty Care Action Plans to improve access in Rheumatology, Dermatology, and Urology on the Anschutz campus and across the state.
- Provided COVID-19 response support through 377 just-in-time ECHO training sessions to providers across Colorado since series inception.
- Launched a collaborative, person-centered transitions of care program for individuals leaving county jails.
- Created a community engagement strategy to engage with the populations and stakeholders impacted by supplemental funding programming.
- Implemented an Access to Health Care Framework to guide project development and evaluation.

[1] Includes primary and specialty care, excludes emergency department.

Program and Project Highlights

In SFY 2020-21, there were 102 unique investments focusing on access to primary and specialty care, evidence-based practices, access for patients living in under-served rural/frontier areas, telehealth, behavioral health, and other wraparound services for Health First Colorado members. The collaborative approach to this programming focused on initiatives that were not just clinically driven, but that aimed to improve access to care and address social determinants of health.

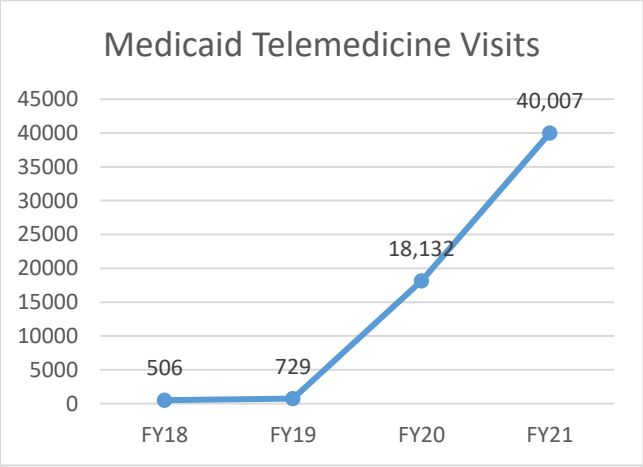
Below are some of the highlights that resulted from the 102 unique investments made in SFY 2020-21:

Dermatology Clinic

Investments were made in a new Dermatology clinic strategically located on the south side of Aurora, CO within an extremely diverse, multicultural neighborhood. This clinic immediately met an urgent community need, seeing rapid growth in patient services provided. In SFY 2020-21 this clinic served a total of 1,196 unique Health First Colorado patients for 1,910 visits. This is the only location in Colorado currently providing electrolysis services to Health First Colorado insured transgender patients.

Telemedicine Growth

Additional funding and resources were provided to drastically increase telemedicine visits by 120% over the SFY 2019-20 visit volume. Over half of all CUSOM providers now regularly incorporate telemedicine into their practices.[2] CUSOM provided telemedicine visits to Health First Colorado members across the state of Colorado and to members living in all 64 Colorado counties. 9% of all Health First Colorado telemedicine visits were provided for members living in Rural or Frontier counties.



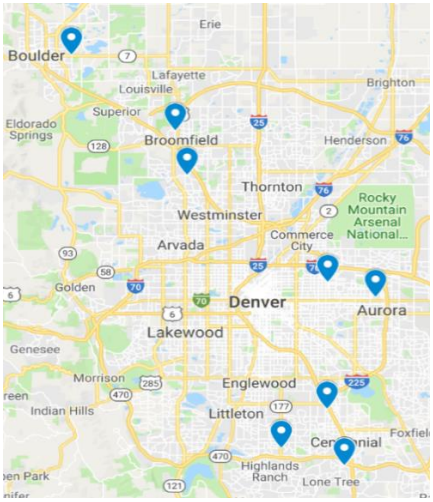
Pediatric specialties provided the highest volume of Health First Colorado telemedicine visits in SFY 2020-21, with Neurology, Gastroenterology, and Developmental Pediatric specialties providing the most visits.

[2] Includes ALL CUSOM providers, including procedural specialties

Aurora Community Health Commons

In 2018, Salud Family Health Centers purchased 27 acres of land to create a community development called the Aurora Community Health Commons (ACHC). The ACHC will include a Federally Qualified Health Center (FQHC) that will provide healthcare services to community members in three ZIP codes identified as having an extreme need for primary care providers. This FQHC will be a CUSOM training site for Family Medicine and Internal Medicine physicians as well as other members of the healthcare team. In SFY 2020-21, CUSOM signed an operating agreement with Salud that defines the mission, targets, and desired outcomes of the ACHC. $25 million has been committed over the next 5 years to support ACHC planning, development, and launch, in addition to $10 million over the next five years to create a Center for Health Equity to be co-located at the ACHC site. This multi-year, collaborative, community-based project brings an innovative approach to investment in health care delivery, workforce education and training, and social determinants of health in Aurora.

Integrated Virtual and In-Person Behavioral Health in Primary Care



SFY 2020-21 was the first full year of implementation for CUSOM's multi-site initiative integrating in-person and virtual behavioral health and psychiatry services across 7 primary care sites in the Denver area. All 7 clinics are in various stages of implementation with many providing services while in the process of hiring and onboarding additional members of the care team to include psychologists, psychiatrists, and clinical coordinators. This project has benefitted 1,016 Health First Colorado members in SFY 2020-21 with crucial behavioral health support during the ongoing mental health crisis during the COVID-19 pandemic. There are also plans to rapidly increase availability of these services in SFY 2021-22.

Inclusion Initiatives

In SFY 2020-21, funding supported expansion of the TRUE (Trust, Respect, Understand, Emerge) Center in order to increase access to medical and behavioral health services for Colorado's gender diverse children and adolescents. Expansion allows for more efficient new patient intake, reduced current waitlists, and increased appointment availability to accommodate the increasing number of new and established patients throughout the state. Additionally, the recruitment of a transgender surgeon was supported to fulfill transgender patients' service needs and has since served a significant number of Health First Colorado members. The expanded use of telehealth and eConsults has improved service delivery and access, especially for Health First Colorado members and patients living in rural and frontier areas.

Additionally, the program supports the Integrated Transgender clinic which is one of the only adult programs in the country that provides a same-day, multi-specialty integrated visit. The three key outcomes of this clinic are:

- Clinical Care: Provided 157 clinical visits for Health First Colorado members in SFY 2020-21.
- Education for patients, staff, and providers: 316 unique participants joined in Transgender ECHO series.
- Quality Improvement and Community Involvement: Enabled a quarterly Community Advisory Board comprised of community providers, transgender and gender diverse patients, and community organizations serving transgender and gender diverse populations to garner input on the clinical care provided at the Integrated Transgender Clinic.

Rural Track and Diversity Scholarships

Over $2 million was invested in SFY 2020-21 for Rural and Diversity Scholarships for MD students at the School of Medicine. With every million dollars of scholarship support, CUSOM can fund 4-6 full tuition scholarships or twice that many at half tuition for four full years. These scholarship dollars are crucial to recruiting the most talented students from diverse backgrounds. Since this program inception, there has been more than 35 students granted either full or partial tuition scholarships in the MD program and the first funding year group is planning to graduate in SFY 2022-23.

Collaborative Initiatives

A concerted effort between CUSOM and the Department was made in SFY 2020-21 to enrich the collaboration in program design, project development and investment, and community engagement.

Enhancing Medical Services Available for Individuals Experiencing Homelessness

CUSOM conducted a listening tour to learn about the gaps, opportunities, successes, and challenges of serving unhoused Health First Colorado members in the community.

- 19 organizations were consulted, including an additional round table discussion at the Aurora Health Alliance's spring quarterly meeting (46 attendees).
- Information was gathered to identify areas of opportunity and reduce duplication of efforts.
- 50+ unhoused individuals were interviewed in the listening tour to share their lived experience of homelessness in the Denver metro area and how they would like to ideally receive healthcare in the future.

Information gathered from these listening sessions will be incorporated in the SFY 2021-22 strategy for implementing programs and services that support Health First Colorado members experiencing homelessness.

Programs for Individuals Transitioning Out of County Jails

A key collaboration area is enhancing transitions of care for individuals previously and currently incarcerated in county jails. A main objective of this work is to increase access to care for incarcerated individuals by initiating relationships with the medical community during incarceration, then bridging successful transitions back to the community. A Corrections Program Manager was hired to initiate a transitions of care partnership between CUSOM, UCHealth, and Arapahoe County Jail. This multi-year program will work to strengthen relationships between county jails and the medical community, provide advocacy for incarcerated individuals, increase retention in medical care for justice involved populations, and evaluate data to develop transitions of care best practices. Future phases of this program include an over $400k annual investment to build the program, expand to other counties, include specialty care access, and develop a person-centered care team to provide wrap-around services and supports.

State Benefit of Program Continuity

Moving into SFY 2021-22, this program is well-positioned to continue work in the five strategic priority areas. These priority areas have been updated from SFY 2020-21 to reflect the current scope of work and are as follows for SFY 2021-22:

1. **Project Evaluation:** Build upon a strategic pivot from project approval and program ramp-up to existing project evaluation. A formal evaluation unit is in process of hiring and implementing a rapid, robust evaluation arm to the program.
2. **Specialty Care Access:** Implementation of the Specialty Care Action Plan designed to improve access in Urology, Dermatology, and Rheumatology. Tracking improvement efforts to determine successes and continued challenges in specialty care access.
3. **Community Engagement:** Administer an enhanced strategy which will focus on addressing identified community engagement gaps and increasing the collaborative material and forums with community partners.
4. **Telehealth:** Facilitate partnership to explore opportunities for information exchange, guidance, and dissemination for telemedicine, eConsults, and ECHOs.
5. **Collaborative Initiatives:** Define, implement, and evaluate collaborative projects that work to increase access to care and improve outcomes for populations with high health care needs across the state.

Overall SFY 2020-21 was met with many challenges associated with COVID-19, however program teams at both the Department and CUSOM continuously adapted to support this program's ongoing services to Health First Colorado members. The positive, collaborative relationship between the Department and CUSOM program teams is a model of two distinct organizations working together for the benefit of improving health care access and outcomes for the most vulnerable citizens in Colorado.

Appendix A – Project-level Expenditure Report
SFY 2020-21

IA Section	Project #	SFY21 Funds Spent
Section 5.1. Expand Medicaid Member Volumes		**$39,469,035.46**
Enhanced Clinical Payments	510001	$39,469,035.46
Section 5.2. Expand Access and Enhance Care Using Evidence-Based Health Care Delivery Models		**$16,829,048.61**
Adolescent Medicine Behavioral Health Integration	520002	$130,672.76
BC4U LCSW	520003	$96,351.03
CHCO Primary Care Operations: Care Coordination	520004	$541,862.58
Young Mother's Clinic Psychosocial Support	520005	$162,673.61
Integrated Behavioral Health Services for Children with Medical Complexity in the Outpatient Setting	520007	$255,413.80
Special Care Clinic Pharmacy Support	520008	$143,055.15
Multidisciplinary Asthma Clinic (MAC)	520009	$102,298.98
Improving Outcomes in High Risk Children and Adolescents with Type 1 Diabetes	520010	$567,236.56
Integrated Care in Family Medicine: Virtual and In-person Integrated Behavioral Health Services	520011	$1,364,828.96
Promise Clinic	520012	$718,954.10
Child Health Clinic Behavioral Health Integration	520013	$614,407.89
AF Williams Care Coordination	520014	$24,335.00
Ambulatory Nicotine Cessation Program	520015	$118,564.86
Aurora Wellness Network - Just Keep Breathing	520016	$167,302.58
Aurora Wellness Network - Community Health Navigators in School-Based Health Centers	520017	$109,252.88
Aurora Wellness Network - Clinical Process Improvement Strategies	520018	$185,533.40
Aurora Wellness Network - Advanced Data Analytics	520019	$96,101.53
Aurora Wellness Network - Primary Care	520020	$299,776.59
Aurora Wellness Network - Medical Legal Partnership	520022	$192,717.05
Adult Medicaid GI Access	520023	$107,784.91
Behavioral Health Services for Cystic Fibrosis Patients	520024	$199,187.42
Population Health Focused Clinical Pharmacy Services in Primary Care	520025	$129,343.76
Special Care Clinic Program Support	520026	$129,397.50
TRUE Center Expansion	520027	$453,989.93
CIDE Assistive Technology Clinic	520028	$308,686.11
Connections Program for High-Risk Infants and Families	520029	$585,129.25
Enhancing HIV Care Through the Patient-Centered Medical Home Model	520030	$126,830.19
CHCO Primary Care APM and Payment Reform	520031	$107,514.45
Warm Connections	520032	$271,069.50
Pregnancy Medical Home for OBGYN UCHealth Practices	520033	$215,633.31
HCPF Consulting Services	520034	$544.06
Motivational Interviewing Training	520035	$200,377.09
Primary Care Community Practice PCMH Support	520036	$692,487.02
UCHealth Integrated Transgender Program Expansion	520038	$276,646.90
Psychiatry BH Integration Women's Health Service Line	520039	$940,170.73
UCHealth Integrated Transgender Surgeon MW	520040	$62,392.62
ARTS Increasing Access to Medication Assisted Treatment	520041	$1,399,594.72
ARTS Synergy Adolescent Program	520042	$477,755.60
Practice Innovation Program	520043	$1,820,161.10
Primary Care Clinical Informatics Fellow	520044	$73,279.64
CU Dermatology Clinic	520045	$274,123.72
Colorado Springs Pediatric Diabetes Center	520046	$544,735.26

University of Colorado Medicine Geriatric Medicine (formerly known as KAVOD - Senior Primary Care)	520047	$35,471.63
CU Community of Practice Pharmacy Support	520049	$54,525.68
Functional Neurological Disorders (FND) Clinic	520050	$435,180.79
HealthySteps implementation in Primary Care at CHCO	520051	$410,018.79
Behavioral Health Supports for Individuals with Down Syndrome in a Multidisciplinary Clinic	520052	$97,019.05
Addiction Treatment for Medically Complicated	520053	$508,658.57
Section 5.3. Expand Targeted Rural Patient Access		**$4,336,712.65**
Peer Mentored Care Collaborative (ECHO & eConsult)	530001	$1,095,515.98
Outreach Coordinator	530002	$80,982.06
Statewide Facilitation of Care for Sickle Cell Disease and Other Hemoglobinopathies in Colorado	530003	$201,246.23
Children and Youth with Special Health Care Needs (CYSHCN)	530004	$114,771.69
Autism and Developmental Disabilities Program (ACCESS)	530005	$650,579.74
Colorado Pediatric Psychiatry Consultation & Access Program (CoPPCAP)	530006	$407,050.88
Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP) Rural Training Program	530007	$29,804.13
Colorado Statewide Youth Suicide Prevention Initiative	530008	$601,115.77
Pediatric Pulmonary and Sleep Service Expansion to Grand Junction	530009	$81,721.82
Pulmonary Sleep Outreach to Durango & Cortez	530010	$7,152.31
CAMP: Expansion of the Obstetric Medical Home Model for Adolescent Pregnancy	530011	$249,320.00
Colorado Hospitals Substance Exposed Newborn Quality Improvement Collaborative (Chosen QIC)	530012	$556,450.99
Digestive Health Intestinal Rehab Telehealth	530013	$18,925.38
Digestive Health Psychology Support	530014	$37,445.82
Pediatric Asthma and High Risk Asthma in Colorado Springs	530015	$104,170.19
Cystic Fibrosis Travel	530016	$1,120.00
Foot Care Clinic for Adult Homeless Population in Colorado Springs	530017	$2,336.50
Pediatric Cardiology Outreach Southern Colorado	530018	$50,714.06
Tele-enabled Community-based Rheumatology in Rural and Frontier Colorado	530019	$46,289.10
Section 5.4. Expand Telehealth		**$1,991,845.69**
CORE e-Consult Provider Reimbursement	540001	$326,200.00
Family Planning/BC4U Telehealth Expansion	540002	$219,087.25
Telespine Triage	540003	$11,010.50
Colorado Fetal Care Center Telehealth	540004	$260,789.80
Expanding Access to Integrated Substance/Mental Health Treatment for Adolescents and Young Adults	540005	$337,911.07
Delivery of Telehealth Pre-Exposure Prophylaxis (PrEP) for HIV Prevention	540006	$194,683.95
Teleneurology Service for ED and Inpatient Consults	540007	$199,133.67
Creation of the University of Colorado Program for Diabetes and Endocrine Virtual Care	540008	$96,604.37
COVID-19 Response	540009	$274,811.89
GIM Telehealth Expansion	540010	$31,230.93
Teleneurology for Movement Disorders	540011	$40,382.26
Section 5.5. Improving Transition of Care and Patient Follow-up		**$1,058,164.46**
CHCO HIV Transitions	550001	$318,221.55
Post-Discharge Telehealth Home Nursing Visits for Medically Complex Children at High Risk for Readmission	550002	$164,206.00
Pediatric to Adult Transition of Patients with Asthma	550003	$104,846.40
Adults in Special Care Clinic	550005	$246,914.49
Behavioral health Access for Refugees and Immigrants	550006	$161,194.36
STRIDE UCH Inpatient Care Management	550007	$51,750.00
Transition to Adult Care and Adult Models of Care	550008	$11,031.66
Section 5.6. Support for Federally Qualified Health Centers (FQHCs)		**$532,220.73**
Aurora Community Health Commons (ACHC)	560005	$532,220.73
Section 5.7. Farley Health Policy Center		**$479,522.90**

Farley Health Policy Center	570001	$479,522.90
Section 5.8. Support for Rural and Diversity Programs		**$2,030,000**
Rural Scholarships	580001	$100,000
Rural Track Program Support	580002	$100,000
Diversity Scholarships	580003	$1,830,000
Section 5.9. Collaborative Initiative Funding		**$5,864,403.20**
CU Medicine Operational Expenses	590001	$900,047.07
Specialty Area Initiatives: Urology	590003	$18,114.62
Specialty Area Initiatives: Dermatology	590004	$2,091.45
Specialty Area Initiatives: Rheumatology	590005	$24,480.00
Specialty Area Initiatives: Corrections Transitions	590006	$1,070.69
Homeless Services Initiatives	590007	$25,939.55
Center for Health Equity	590008	$18,701.54
CU Community Practice COVID Operations Support	590009	$1,973,958.28
Primary Care Practice Support	590011	$2,900,000.00
Total		**$72,590,953.69**

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

October 8, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Multi-Department Request for Information #5 regarding the programs funded with Tobacco Master Settlement moneys.

Each Department is requested to provide the following information to the Joint Budget Committee by October 1, 2021 for each program funded with Tobacco Master Settlement Agreement money: the name of the program; the amount of Tobacco Master Settlement Agreement money received and expended by the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals.

The Department is allocated Tobacco Settlement funding for the Children's Health Plan *Plus* (CHP+) and Children's Autism Program, and the attached report contains the programmatic information of the two programs. In the report, you will find an overview of the program, prior year financials, strategic priorities and key goals, partner relationships, program measures of success, and program opportunities and challenges.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director

KB/maq

Enclosure(s): Health Care Policy and Financing FY 2020-21 Multi-Department RFI #5

CC: Representative Julie McCluskie, Vice-chair, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Bettina Schneider, Finance Office Director, HCPF
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Bonnie Silva, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Multi-Department LRFI #5 (Tobacco Master Settlement Agreement)

Joint Budget Committee's Multi-Department Request for Information #5 regarding the programs funded with Tobacco Master Settlement moneys

October 8, 2021

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Children's Basic Health Plan

A. Program Overview:

Program Description:	The Children's Basic Health Plan, known as the Child Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families, up to 260% of the Federal Poverty Level (FPL), who do not qualify for Medicaid and do not have private insurance. The program is primarily funded by tobacco settlement monies deposited in the Children's Basic Health Plan Trust, Healthcare Affordability and Sustainability Fee cash fund, and federal funds.
Eligible Population:	Uninsured children from 143% FPL to 260% FPL and uninsured pregnant women from 196% FPL to 260% FPL.
Tobacco Settlement Monies Received:	FY 2020-21: $14,464,690

Services:	**Number of Eligible Persons Served:**
Affordable health insurance and oral health care for CHP+ children and Prenatal Clients.	In FY 2020-21, average monthly caseload for CHP+ was 66,187 (65,421 children and 766 pregnant adults).

B. Strategic Priorities and Key Goals

- Reduce the number of uninsured children and pregnant adults under 260% FPL that are not eligible for Medicaid.

C. Measures of Success:

Program Outputs	Program Outcomes
• In FY 2020-21, CHP+ provided health care to an average monthly caseload of 66,187 children and pregnant adults who would have otherwise been uninsured. This represents a 14.56 percent decrease in the average monthly enrollment over FY 2019-20.	• Providing affordable health insurance to children under the age of 19 and pregnant women in low-income families who do not qualify for Medicaid and do not have private health insurance. • Offering a defined benefit package that uses privatized administration.

D. Program Opportunities and Challenges:

The COVID-19 pandemic has continued to introduced challenges for the CHP+ program throughout FY 2020-21 as the state of Colorado responds to the ongoing Public Health Emergency (PHE). The PHE has presented opportunities for the state to implement programmatic and regulatory changes in support of public health. However, the need to modify policies and procedures to facilitate access to coverage and care has continued to shift limited resources to focus on responding to the public health crisis. Additionally, the Maintenance of Eligibility (MOE) provision introduced in the Families First Coronavirus Response Act (FFCRA), which requires states to maintain eligibility for Medicaid beneficiaries until the end of the PHE, has caused a decrease in CHP+ program enrollment, bringing the average monthly caseload to 66,187 children and pregnant adults during FY 2020-21.

The COVID-19 PHE also introduced a unique challenge to ensure CHP+ members are completing vital primary and preventative care visits. Throughout the pandemic, rates of vaccinations, primary, and preventative services among children has declined, which may impact long-term health outcomes for children. In response, the Department has taken steps to introduce flexibilities in accessing care via telehealth and will continue to collaborate closely with CHP+ Managed Care Organizations (MCOs) to ensure children catch up on missed vaccines, preventative services, and maintain access to care.

Despite the challenges presented during FY 2020-21, significant strides were made in CHP+ program improvement. In 2018, through the HEALTHY KIDS and ACCESS Acts, federal funding for the CHP+ program has been extended through

FFY 2026-27. This long-term funding extension has allowed the Department to focus on strategic improvements to modernize the CHP+ program. Throughout FY 2020-21, a priority for the Department has been to identify key areas of alignment between the CHP+ program and the Accountable Care Collaborative (ACC) program, and therefore bring the CHP+ program into increased alignment with the overall goals of improving member health, furthering performance outcomes, and reducing the cost of care for Coloradans. In alignment with those objectives, key areas of focus within the CHP+ program have included:

- Establishing increased alignment between the requirements for CHP+ and Medicaid MCOs
- Improving the exchange of necessary data and information to more effectively monitor program performance and member health
- Identifying key outcome and performance metrics to strengthen reporting requirements and consistency across CHP+ MCOs so the Department can better measure and manage the quality and cost of care across the CHP+ program
- Building the foundation of quality metrics, performance goals, and strategies to hold CHP+ MCOs accountable for achieving benchmarks
- Providing a framework for identifying targeted populations and conditions to ensure consistent application of evidence-based programs across CHP+ MCOs
- Identifying areas to improve operational processes and performance
- Fostering increased engagement with key stakeholders and improving mechanisms for collaborating in the sharing of ideas and best practices

As part of the effort to modernize the CHP+ program, at the end of FY 2020-21, the Department ended the State Managed Care Network (SMCN), the administrative service organization (ASO) for the CHP+ program. Moving forward, all CHP+ eligible members will be enrolled into a managed care organization. This expansion of a managed care delivery model within the CHP+ program represents improved continuity of care for members and a reduction in duplicative administrative tasks through leveraging the Department's capabilities and infrastructure. Additionally, during FY 2020-21, the Department was granted approval from CMS for a five-year extension of the state's 1115 Prenatal Demonstration. This Demonstration will continue to allow the state to receive Title XXI funds to support increased access to high-quality prenatal, delivery, and postpartum care, and improved health outcomes for low-income mothers and their babies.

FY 2020-21 represented significant strides toward improving and modernizing the CHP+ program. The Department will leverage the successes of the past year to continue pursuing strategic programmatic improvements, seek feedback and recommendations from key stakeholders to identify opportunities for alignment between CHP+ and Medicaid, and implement overall strategies to further improvement in the CHP+ program.

II. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

A. Program Overview

Program Description:	HB 16-1408 added Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to the services covered by the Colorado Autism Treatment Cash Fund. Starting in 2016, behavioral therapy services were moved out of various HCBS programs, including all children's waivers, into the EPSDT benefit. These services are funded by tobacco settlement monies deposited in the Colorado Autism Treatment fund, General Fund, and federal funds.
Eligible Population:	Per C.R.S. 25.5-6-805 the Colorado Autism Treatment fund was created for the purpose of paying for services provided to eligible children, EPSDT services, and program and participant evaluations. Eligible children are children under the age of six that have received a diagnosis of autism. The EPSDT benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, who are enrolled in Health First Colorado. The only population that is eligible to be funded by the Colorado Autism Treatment Cash Fund, however, are those children with an autism diagnosis and who are under the age of eight at the time of service.
Tobacco Settlement Monies Received:	FY 2020-21: $1,613,611

Services:	**Number of Eligible Persons Served:**
Comprehensive community support treatment, mental health assessment, request for assessment, and adaptive behavior treatment.	1,162 average monthly utilizers under the age of eight

B. Strategic Priorities and Key Goals

- Increase the quality of services to EPSDT children and youth with an autism diagnosis and under the age of eight who have a documented need for pediatric behavioral therapy services.

C. Measures of Success

Program Outputs	Program Outcomes
• Increased quality in provider documentation by standardizing documentation to reduce any unnecessary delays in care • Increased percentage of goals met per child • Increased quality of the prior authorization process	• Serving the children most vulnerable to institutionalization without the services provided with quality services and higher percentage of goals met • Keeping children out of institutions and in their communities • Demonstrating improvement in the child's expressive and receptive communication, adaptive skills, and a reduction in the severity of the child's maladaptive behavior, including self-injurious or aggressive behavior and tantrums, through the use of standardized and norm-referenced treatment and assessments

D. Program Opportunities and Challenges

On September 14, 2015, the Centers for Medicare and Medicaid Services (CMS) denied the Department's Children with Autism waiver expansion and requested that the State provide the services, when medically necessary, through Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The Department has enrolled providers and is currently providing behavioral therapies to clients through the EPSDT program. Since behavioral therapy was the only service on the Children with Autism waiver, the Department submitted a Waiver Amendment to CMS to phase out the CWA waiver in

2018. The Department stopped all program and waitlist enrollments on January 2, 2018 and ended operations on July 1, 2018. The Department established transition monitoring procedures to work with Case Management Agencies and families to ensure client transitions were appropriate and timely.

In the fall of 2015 CMS also directed the Department to run the Pediatric Behavioral Therapies benefit under EPSDT and remove behavioral services for children and youth 20 years and under from the following waivers: Children's Extensive Support (CES) waiver, Children's Habilitative Residential Program (CHRP) waiver, Developmental Disabilities (DD) waiver and the Supported Living Services (SLS) waiver. The Department transitioned all children and youth 20 years and under from waiver behavioral services to Pediatric Behavioral Therapies in FY 2017-18. It is important to note that members who are receiving EPSDT and behavioral services must also meet eligible criteria of the Colorado Autism Treatment Cash Fund statute. The member must have an autism diagnosis and be under the age of eight.