Department of Regulatory Agencies

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-01 Implementation of Primary Care and Maternal Health APMs

Dept. Approval By: 10/25/21 ____ **Supplemental FY 2021-22**

OSPB Approval By: ____________ ____ **Budget Amendment FY 2022-23**

X **Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$250,000**	**$0**
	FTE	95.9	0.0	96.1	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$250,000	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Division of Insurance, (A) Division of Insurance, (1) Division of Insurance - Personal Services	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$250,000**	**$0**
	FTE	95.9	0.0	96.1	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$250,000	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Regulatory Agencies Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Regulatory Agencies
Division of Insurance

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Patty Salazar
Executive Director

Department Priority: R-01
Request Detail: Implementation of Primary Care and Maternal Health APMs

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$6,993,579	$250,000	$400,000
FTE	86.3	0.0	0.0
General Fund	$0	$0	$0
Cash Funds	$6,993,579	$250,000	$400,000
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

The Division of Insurance (division) is requesting $250,000 in FY 2022-23 and $400,000 in FY 2023-24 to support the implementation of statewide, all-payer alternative payment models (APMs) for primary care and maternity care in the commercial health insurance market. The primary care and maternity care APMs will be developed in partnership with the Departments of Health Care Policy and Financing (HCPF) and Personnel and Administration (DPA) to establish an aligned approach to value-based payment across public and private payers in Colorado. This aligned approach will maximize the capacity of APMs to improve health outcomes, reduce health disparities, improve care quality, and reduce health care costs, so that all Coloradans will have equitable access to affordable, high-quality primary and maternity care. This request is a one-time funding request for FY 2022-23 and FY 2023-24 only, and represents a one-time budget increase of 3.6% and 5.7%, respectively. The request will also inform and support the division's implementation of multiple health insurance affordability initiatives, including existing and future work on primary care, the reinsurance program, and the Colorado Option.

Current Program

This funding request supports the implementation of statewide primary care and maternal care APMs in the commercial health insurance market, and is being submitted in coordination with the Department of Health Care Policy and Financing (HCPF), which will be implementing the same APMs in Health First Colorado (Colorado Medicaid). While the division and HPCF are submitting separate budget requests, the goal of funding for each agency will be to support the successful implementation of aligned APMs. The division will support commercial carriers' adoption of the APMs using existing regulatory authority.

History and background

APMs, also known as value-based payment models, are health care payment methods that use financial incentives to promote greater value, including higher quality care at lower costs, for patients, purchasers, and providers. Unlike traditional fee-for-service (FFS) payments, which pay for the volume of care delivered, APMs utilize cost and quality control strategies that benefit consumers by increasing the value of care delivered and, ultimately, the affordability of care.

While Colorado has a history of driving toward value-based payments in a competitive marketplace, the state does not currently have an aligned, statewide approach to APMs. Research has demonstrated that value-based payment models are more likely to be successful in improving quality and reducing costs when adopted by multiple payers.[1] Multi-payer alignment around payment incentives and performance measures can simplify provider participation in APMs by establishing common sets of quality metrics, reporting requirements, and practice expectations.[2]

The division is currently partnering with HCPF and DPA, under the leadership of the Office of Saving People Money (OSPMHC), to develop Colorado-specific, consensus-based primary care and maternity APMs that align payment approaches for private (fully-insured, self-funded plans) and public payers (Medicaid, Medicare, and state employee health plans). HCPF has contracted with Bailit Health Purchasing, LLC, (Bailit Health) to facilitate this process, which will be completed in FY 2021-2022 (funding for this work is not part of this budget request). Bailit Health will convene a multi-stakeholder APM Alignment Work Group to determine the parameters for each APM, which will be finalized in late spring 2022.

This division will use this funding request to support implementation of the aligned primary care and maternity care APMs in Colorado's commercial market.

Intended outcomes of aligned primary care and maternal care APMs - marketwide

[1] Rajkumar, R. et al. (2014). Journal of the American Medical Association. CMS- Engaging Multiple Payers in Payment Reform

[2] National Governors Association and Duke Margolis Center for Health Policy (March 2021). State-Driven Initiative to Support Moving to Value-Based Care in the Era of COVID-19

Aligned APMs will accelerate Colorado's shift away from FFS models that drive health care costs and contribute to fragmented care delivery, support the state's achievement of the quadruple aim (healthier people, better care, smarter spending, happier and more satisfied providers)[3], and drive the following system level outcomes:

- Increased access to high-quality primary care and maternal care services;
- Improved health outcomes and reduced health disparities;
- Improved patient and family engagement and increased patient and provider satisfaction; and
- Reduced health care costs.

Intended outcomes specific to primary care and maternal health include:

- Reduced ambulatory-sensitive emergency department (ED) utilization (and costs);
- Reduced ambulatory-sensitive hospitalizations (and costs);
- Reduced maternal mortality rates; and
- Reduced cesarean sections and other potentially avoidable complications.

Additional intended outcomes - division specific

The division is currently pursuing multiple initiatives to increase the affordability of health care for Coloradans, including efforts to reduce consumer costs by lowering health insurance premiums and out-of-pocket costs. Yet making health insurance more affordable does not necessarily reduce underlying costs or ensure Coloradans have equitable access to high-quality, culturally responsive care that meets their health care needs. The division is taking additional actions to improve the quality and value of health care, and to identify and reduce health disparities. The implementation of aligned primary care and maternity care APMs will support and inform the division's short and long-term affordability agenda as follows:

- H.B. 19-1168 and S.B. 20-215 - Colorado's reinsurance program, established under H.B. 19-1168 and extended by S.B. 20-215, promotes cost-effective health care coverage by requiring carriers to pursue care management activities for members with claims that fall within the program's payment parameters. While the reinsurance program is focused on high-cost members, the care management strategies used to control costs for these patients (e.g., patient-centered approaches) can also support the delivery of high-quality primary care and maternal health services across entire patient populations. The implementation of primary care and maternal health APMs that align carriers' care management approaches will maximize the collective impact of such strategies, and strengthen the reinsurance program.

- H.B. 19-1233 - H.B. 19-1233 directs the state to implement payment system reforms that reduce health care costs by increasing utilization of primary care. The legislation established the Primary Care Payment Reform Collaborative (PCPRC) to develop strategies for increasing investment in primary care, and gave

[3] Forrester, R. (2020). How the Quadruple Aim and Value-Based Care Intersect

the division authority to consider the affordability of carriers' products as part of the rate review process. In annual reports released in December of 2019 and 2020, the PCPRC has recommended that increased primary care investments should primarily be made through APMs that offer prospective funding and incentives for improving quality,[4] and strongly supported multi-payer alignment, deemed crucial to the success of APMs in Colorado.[5]

The division adopted Colorado Regulation 4-2-72 in December 2020, which requires health insurance carriers to increase the proportion of total medical expenditures allocated to primary care by one percentage point in calendar years 2022 and 2023, and sets a proposed target that 50% of a carrier's total medical expenditures be made through APMs by the end of calendar year 2022.[6] The convening of an APM Alignment Work Group by Bailit Health will support the division's development of a future APM target by allowing engagement with stakeholders and technical experts who are not currently represented on the PCPRC but whose participation will be critical to the success of the aligned APM.

- H.B. 21-1232 - H.B. 21-1232 directs the Insurance Commissioner to establish a standardized health benefit plan that must be offered by all carriers in the individual and small group markets. In addition to offering essential health benefits, the standardized plan must have a benefit design and cost-sharing that improves access, affordability, and racial health equity using a variety of strategies, including first-dollar, pre deductible coverage for high-value services (primary and behavioral health care) and improved coverage of perinatal health. Aligned primary care and maternal care APMs may be relevant considerations in supporting the delivery of such benefits in the later stages of H.B. 21-1232 implementation.

- S.B. 21-194 - S.B. 21-194, passed as part of a package of birth equity bills, addresses racial inequities and other disparities in infant and maternal care by requiring commercial carriers and Health First Colorado to reimburse providers offering labor and delivery services in a manner that promotes high-quality, cost-effective, and evidence-based care, and high-value, evidence-based payment models. The implementation of an aligned maternal care APM will directly address the requirements of S.B. 21-194.

Evidence supporting efficacy of multi-payer APMs in Colorado

Payers and providers in Colorado have been at the forefront of primary care delivery and payment reform efforts for well over a decade, participating in several state and federal multi-payer models:

[4] Colorado Primary Care Payment Reform Collaborative, First Annual Report, December 2019

[5] Colorado Primary Care Payment Reform Collaborative, First Annual Report, December 2020

[6] Colorado Insurance Regulation 4-2-72

- Comprehensive Primary Care (CPC) (2012-2016) - CPC was a national four-year multi-payer initiative aimed at strengthening primary care through a core set of "comprehensive" primary care functions. In Colorado, over 70 practices, serving more than 400,000 patients, participated in CPC. CPC evaluation findings showed:
  - Reduced hospitalizations and ED visits for Medicare FFS beneficiaries at the national level;
  - Substantial practice-level improvements in risk-stratified care management, expanding access to care, and continuous improvement driven by data;
  - Colorado was one of four participating regions (out of seven) to generate savings in Program Year 2015, which totaled more than $13 million across the regions.[7]

- Colorado Multi-Payer Collaborative (MPC) (2012 - Present) - The Colorado Multi-Payer Collaborative (MPC) was formed to facilitate and support multi-payer participation in CPC, and has continued to support payer alignment around subsequent payment reform initiatives. At the time of its inception, the MPC consisted of 10 private and public payers, and today the group has 6 participating members. The MPC's contributions to payment reform in Colorado include:
  - Creating a shared framework for care delivery transformation; and
  - Developing aligned sets of quality measures for adult and pediatric patients, which are being incorporated into value-based provider contracts across participating payers.

- State Innovation Model (SIM) (2014-2019) - In 2014, Colorado received up to $65 million from the Center for Medicare and Medicaid Innovation (CMMI) to test a model to improve the health of Coloradans by increasing access to integrated physical and behavioral health care. Over the course of the initiative, 344 primary care practices and four Community Mental Health Centers across the state participated in SIM, supported by seven public and private payers. SIM evaluation findings showed:
- Improvements in outcome measures across four domains: integration (changes integrated care delivery, provider satisfaction, and patient engagement); access to care; clinical outcomes; and cost and utilization;[8]
- Patients attributed to SIM practices had 2% fewer ED visits from 2015-2017, and had decreased psychiatric ED visits, with 4,350 visits avoided;
- A return-on-investment (ROI) analysis completed by Milliman, Inc. in July 2020 estimated that SIM resulted in $125.9 million in savings, equating to approximately 1.7% of projected health care costs, through 2018. By factoring in CMMI's $62.9 million investment, Milliman projected an ROI of 2.0.[9]

[7] Mathematica Policy Research (2018). Evaluation of the Comprehensive Primary Care Initiative- Fourth Annual Report

[8] A summary of findings from the TriWest Outcome Evaluation Report is available here. A complete version of the TriWest Colorado SIM Outcome evaluation report is available here. A complete version of the TriWest Colorado SIM Process Evaluation Report is available here.

[9] Milliman, Inc. (2020). SIM Healthcare Cost Savings and Return on Investment.

- Comprehensive Primary Care Plus (CPC+) (2017 - 2021) - CPC+ is a national five-year, advanced primary care medical home model focused on strengthening primary care. In Colorado, 189 practices are currently participating in CPC+, supported by four payers (Anthem, Health First Colorado, Rocky Mountain Health Plans, United Healthcare). An evaluation of the first three years of CPC+ found:
    - Small favorable effects on some measures of service use, quality of care, and patient experience;
    - No impact on expenditures for usual services (when enhanced payments to providers are included, Medicare expenditures increased by 2-3%);[10]
    - Reductions in high-cost services such as ED visits, but no impact on ambulatory specialty care visits or urgent care visits.

The Biden Administration has indicated value-based payments will remain an important component of CMS' health care agenda. Liz Fowler, the newly appointed director of CMMI, recently affirmed the administration's commitment to value-based models, noting the agency is currently reviewing its history of demonstration models to determine the best path forward.[11] Priorities for future work will likely include a shift toward mandatory models, which have greater capacity to realize cost savings, as well as increased emphasis on improving health equity and actions to address the social determinants of health.[12] The DOI and HCPF will continue efforts to align health care payment reform in Colorado with these national efforts.

Problem or Opportunity

Governor Polis has placed affordability at the center of his health care policy platform, and made "saving people money on health care" one of his Bold Four priorities. Many of the Administration's legislative successes have focused on providing relief to individuals and families struggling with high healthcare costs. To ensure all Coloradans have equitable access to culturally responsive care, it is also important to look at the underlying cost of care and drive the market toward APMs which can result in higher quality care at a lower cost.

Problem:
The U.S. spends more on health care than other industrialized countries, yet has lower rates of insurance coverage and uneven and often worse population health outcomes.[13] [14] The predominance of a FFS payment system is a major driver of higher costs and poorer quality. By incentivizing the delivery of more care, including care that may be unnecessary and even harmful, FFS increases spending and waste and fails to reward

[10] Mathematica (2021). Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Third Annual Report
[11] Fernandez, M. (2021). Axios. CMS innovation director wants more value-based care models
[12] Ibid.
[13] Erikson, S. et al. (2020). Annals of Internal Medicine. Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms
[14] Tikkanen, R. et al. (2020). Commonwealth. U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?

higher-quality care and improved health outcomes. A 2019 analysis estimated the cost of waste in the U.S. healthcare system ranged from $760 billion to $935 billion, accounting for approximately 25% of total spending; projected potential savings from interventions to reduce waste ranged from $191 billion to $286 billion.[15] FFS payment contributes to fragmented care delivery by failing to reimburse, and in some cases financially disincentivizing, care coordination services between providers, care teams, and social and community-based services that are essential to addressing health equity and the underlying causes of health issues.

While financial distortions in the current FFS payment system harm all patients, black, indigenous, and people of color (BIPOC) are particularly impacted. BIPOC individuals and communities disproportionately face adverse social determinants of health, due to systemic racism and other historical inequities and structural barriers, resulting in persistent health disparities, in both primary care and maternal and infant health:

- People of color are less likely to have access to a usual source of care,[16] but more likely to have a number of chronic conditions;[17]
- Members of racial and ethnic minorities are less likely to receive preventive services, such as cancer screenings, and often receive lower quality care;[18]
- Black and American Indian Alaska Native (AIAN) women have pregnancy-related mortality rates that are over three and two times higher, respectively, compared to the rate for White women (40.8 and 29.7 vs. 12.7 per 100,000 live births);
- Black, AIAN, and Native Hawaiian and other Pacific Islander (NHOPI) women have higher shares of preterm births (birth before 37 weeks gestation), low birthweight births (a baby born less than 5.5 pounds), or births for which they received late (starting in the third trimester) or no prenatal care compared to White women;
- Black and Latino people have been three times as likely to become infected with COVID-19, and nearly twice as likely to die from the virus as White people.[19]

The realigning of payment structures for primary care and maternal care delivery to focus on quality and outcomes, through aligned APMs, can begin to address some of these issues.

The COVID-19 pandemic also highlighted the vulnerability of primary care, which continues to derive the majority of revenue from in-person evaluation and management (E&M) visits, within the current healthcare system.[20] Providers participating in value-based arrangements - including as prospective, population-based payment models that are not tied to the volume of care delivered - demonstrated greater financial resiliency

[15] Frank, S. et al. (2019). JAMA. Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings

[16] Artiga, A. et al. (2019). Kaiser Family Foundation. Key Facts on Health and Health Care by Race and Ethnicity

[17] Thorpe, K. et al. (2017). Health Affairs. The United States Can Reduce Socioeconomic Disparities By Focusing On Chronic Diseases

[18] Hostetter, M et al. (2018). Commonwealth. In Focus: Reducing Racial Disparities in Health Care by Confronting Racism

[19] Oppel, R. et al. (2020). New York Times. The Fullest Look Yet at the Racial Inequity of Coronavirus

[20] Basu, S. et al. (2020). Health Affairs. Primary Care Practice Finances in The United States Amid The COVID-19 Pandemic

in the face of the COVID-19 public health emergency than those relying solely on FFS payments.[21] Lessons learned about the capacity of APMs not only to ensure financial sustainability and viability of providers and practices, but to provide the flexibility needed to orient care delivery to respond to patient needs, can and should be applied to broader efforts to reform the healthcare system.

Proposed Solution

APMs offer states greater opportunities to improve health care value, and can facilitate tailored approaches to address equity, disparities and social determinants of health.[22] Colorado has been a leader in health care delivery and payment reform efforts, and is well-positioned to take the next important step forward by pursuing aligned, statewide APMs in primary and maternal care. Aligned APMs will support the Administration's priorities of reducing health care costs while ensuring culturally responsive and equitable access to care by:

- Reducing underlying cost of care, through risk-based and capitated payment models, which hold providers accountable for the cost of care, and pay for value over volume; and
- Increasing equity and quality of care by focusing resources on patient populations with the greatest health needs, and incentivizing providers to prevent and manage chronic conditions and address social determinants of health.

Resources needed:
The division estimates it will need $250,000 in FY 2022-23, and $400,000 in FY 2023-24 to support the implementation of aligned primary care and maternal care APMs in the commercial market. Funds will be used for the following activities:

1. **APM technical support contractor** - The division is requesting $250,000 in FY 2022-23 and $250,000 FY 2023-24 to retain a contractor that will provide ongoing technical assistance to commercial carriers in implementing the aligned primary care and maternal care APMs. The majority of commercial carriers in Colorado are currently pursuing payer-specific models that may require modification to come into alignment with a statewide all-payer APM. The responsibilities of the APM technical support contractor will include:
    - **Meeting facilitation ($125,000 per year):** Facilitating regular meetings (at minimum 6 each year) with payers to support organizational alignment and consistency in strategies to support practice transformation and improved patient outcomes;
        - Providing technical assistance, in the form of shared tools, operational strategies or other resources, to address payer needs;

[21] Roiland, R. et al. (2020). Duke Margolis Center for Health Policy. Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience
[22] Ibid.

- Developing a policy for managing antitrust considerations and concerns;
    - Assisting with the refinement or adjustment of quality metrics or other model components, based on ongoing model implementation and evaluation;
    - Travel costs, if applicable.
- **Multi-stakeholder symposia ($125,000 per year):** Organizing and facilitating twice yearly multi-stakeholder symposia, bringing payers and providers together to discuss successes, challenges, and other issues associated with model implementation (e.g., practice transformation support);
- Serving as a liaison to the PCPRC, and consulting with division leadership as needed to provide ongoing updates on implementation efforts and surface issues that may require policy or regulatory actions or adjustments.

Studies examining the factors leading to successful multi-payer participation in payment reform initiatives indicate collaboration is improved when participating payers employ neutral, proactive meeting facilitators.[23] In Colorado, the MPC has played a central role in supporting payer collaboration in multiple ongoing health reform initiatives; however, the group is ending in December 2021. The MPC utilized an independent, third-party contractor as a facilitator, which was an important component of the group's success. The division's funding of such a group, starting in FY 2022-23, will allow payers to focus investments on implementation of the aligned primary care and maternal care APMs, rather than devoting resources to pay for a facilitator. The division will engage with MPC members and the current facilitators to identify best practices and lessons learned from the MPC to help structure the contract for a future convenor.

2. **<u>Evaluation of primary care & maternal health APM implementation and impacts -</u>** The division is requesting $150,000 in FY 2023-24 to hire a contractor to design evaluations of the implementation of the primary care and maternal health APMs in the commercial insurance market, and the ongoing ongoing impact of the APMs on health care quality and costs. The responsibilities of the evaluation contractor will include:

    - **Implementation evaluation plan ($50,000)** - Determining metrics (short, medium and long-term), timelines, accountable entities, data sources, and data collection processes to track the implementation of the primary care and maternity APMs by commercial payers and network providers;
    - **Impact evaluation plan ($100,000)** - Determining metrics (short, medium and long-term), timelines, accountable entities, data sources, and data collection processes to track the impact of primary care and maternity APMs in the commercial insurance market; anticipated metrics include, at a minimum, measures to track:
        - Access to care and care quality;
        - Patient and provider engagement and satisfaction;

[23] Anglin, G. et al. (2017). Milbank Memorial Quarterly. Strengthening Multipayer Collaboration: Lessons from the Comprehensive Primary Care Initiative

- Health outcomes for primary care and maternal and infant health;
- Carrier expenditures on primary care and maternal care; and
- Total health care costs.

The contractor will prioritize health equity in the design of the evaluations, and identify data sources (or provide recommendations for the collection of data, where gaps exist) that will allow for measurement and reporting at a disaggregated level to track model impacts on health disparities.

The division does not anticipate statutory changes will be required for this budget proposal.

Evidence/research supporting solution

Primary care:

Evidence shows primary care oriented systems achieve better health at lower cost, and have a more equitable distribution of health in populations.[24] [25] Investments in primary care and practice transform have resulted in improved quality while controlling costs and reducing utilization of unnecessary services,[26] including ED use, hospitalizations for ambulatory-sensitive conditions, and total hospitalizations.[27] Colorado is one of 14 states engaged in efforts to strengthen primary care as a strategy in overall health system reform,[28] and one of six states, to establish a primary care investment target; three states have also incorporated targets for APM expenditures. While many of these efforts are in the initial stages of implementation, state successes to date include:

- Rhode Island, the first state to establish affordability standards for commercial insurers in 2010, which included required carrier investments in primary care while setting a cap on increases in hospital spending. An analysis showed the affordability standards decreased total spending without impacting care quality;[29]
- Capital District Physicians Health Plan (CDPHP), a commercial health plan in New York, saw an annual cost savings of $20.7 million ($17.11 PMPM reduction) after implementing primary care capitation with its provider network.[30] Approximately 60% of this savings came from members in the commercial market, and approximately 20% was associated with the sickest 10% of members in the Medicaid and Medicare markets.

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[24] Starfield, B. (2005). Milbank Quarterly. Contribution of Primary Care to Health Systems and Health

[25] Friedberg, M. et al. (2010). Health Affairs. Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care

[26] Nielsen, M. et al. (2016). Patient-Centered Primary Care Collaborative. The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of the Evidence 2014-2015

[27] Jabbarpour, Y. et al. (2019). Patient-Centered Primary Care Collaborative. Investing in Primary Care: A State Level Analysis

[28] Primary Care Collaborative (2020). State Leadership Highlights

[29] Baum, A. et al. (2019). Health Affairs. Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers

[30] CDPHP Enhanced Primary Care (EPC) Initiative

Maternal Health

APMs for maternal health commonly utilize episode-based payments, which reimburse providers for all clinically appropriate services needed by a specific patient for a particular condition or treatment. Episode-based payments incentivize the optimization of evidence-based care delivery while reducing unwarranted variations in care to maximize savings and improve patient experience and quality outcomes; in maternity care, payments encourage the provision of services such as continuous labor support, or doula care, and breastfeeding support interventions which can improve birth outcomes and lower costs.[31] Examples of state success with episode-based APMs include:

- Medicaid programs that have an active or developing episode-based payment system, including Arkansas, Connecticut, Ohio, Oklahoma, New York, and Tennessee, offer or require the methodology to be used for maternity services. Data is available for Arkansas and Tennessee's programs. Based on preliminary data, Arkansas has seen a 3.8% drop in perinatal episode expenditure and Tennessee has seen a 7.7% drop.[32]
- Horizon Blue Cross Blue Shield of New Jersey, a commercial insurer in New Jersey, reported that members in practices participating in the company's Episodes of Care (EOC) model, which includes a maternity bundle, had a far lower hospital readmission rate and experienced other high quality outcomes compared to members receiving the same services from a non-EOC practice, including a 32% reduction in unnecessary pregnancy C-Sections.[33]

Theory of Change	The adoption of aligned, statewide multi-payer alternative payment models (APMs) in Colorado will improve care delivery, health outcomes, and increase health equity and care quality and lead to reduced health care costs over time.		
Program Objective	Implement primary care and maternal care APMs in the commercial insurance market that are aligned with public payers including Health First Colorado and state employee health plans.		
Outputs being measured	Number of commercial payers implementing the aligned primary care and maternity care APMs		
Outcomes being measured	Anticipated (to be determined): improved quality of care, decreased health disparities, reductions in total costs of care over time		
Cost/Benefit ratio	None at this time; to be determined		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial

[31] HCP-LAN Maternity Multi-Stakeholder Action Collaborative. Issue Brief: The Business Case for Maternity Care Episode-Based Payment

[32] Bailit Health and the National Association of Medicaid Directors (2016). The Role of State Medicaid Programs in Improving the Value of the Health Care System

[33] University Hospital in Newark and Horizon Blue Cross Blue Shield of New Jersey Announce Value Based Care Collaborative

Results of Evaluation	Evaluation will include such elements as the frequency of commercial carriers adopting APMs, as well as study of whether quality of care improved, disparities decreased, and cost reductions occurred.	n/a	n/a
Continuum Level	Step 4		

Consequences if not approved

If this request is not approved, commercial carriers are less likely to adopt aligned primary care and maternity APMs and continue to pursue organization-specific models. Fragmented payment approaches increase the administrative burden on providers, discourage APM participation, reduce APM impact, and do not improve health care value. Lack of payer alignment will hamper the achievement of sustainable improvements in care delivery and health outcomes, and reduce or potentially negate cost savings. Colorado's current health care affordability initiatives will be more impactful and see greater ROI if payers have aligned APM strategies.

Value-based payments are crucial to the state's achievement of health equity goals. Continued reliance on FFS payment structures will perpetuate ongoing barriers to the provision of person-centered, culturally responsive care, and the resulting health disparities.

Payers and providers in Colorado have a strong history of innovation, and have invested significant time and resources into care delivery and payment reform efforts. Multi-payer efforts focused on primary care and integrated behavioral health have shown positive results, but without continued and sustained support, advances in care delivery achieved through multi-payer alignment may be lost.

As Colorado's response to COVID-19 shifts from managing the public health emergency and toward economic recovery, Colorado's primary care practices cannot be left behind. Evidence indicates primary care practices and providers continue to struggle financially in the wake of the COVID-19 pandemic. APMs that include prospective, up-front payments and provide sustained support for care delivery transformation will improve the financial resilience of current providers, and may serve as an incentive for future providers to enter practice in primary care and maternal and infant health care. In addition, the financial impacts of COVID-19 may give new impetus for providers who may have been hesitant in the past to transition to value-based payments.

Anticipated Outcomes

If the proposal is approved, the anticipated outcomes of aligned, statewide all-payer APMs for primary care and maternal care include improved access to care, improved care

quality, and improved health outcomes. The development and implementation of the primary care and maternal care APMs will prioritize health equity, and include measures and payment incentives to track and reduce racial and ethnic and other health disparities.

The transformation of existing primary care and maternal care systems will require significant investment. Providers will need support in adopting new work processes and workflows, gaining competencies around the use of data, and acquiring the financial management skills required to accept risk. In the commercial market, this work will be supported in part through the carrier primary care investment targets established by Colorado Regulation 4-2-72.

Over time, investments in preventive care and other high-quality services will generate significant system savings, through reductions in chronic conditions and unnecessary utilization that drive health care costs. However, the overall realignment of system financial incentives away from waste and unnecessary services toward high-quality care that improves health outcomes will take time. In the initial phases of this work, the impact on costs is anticipated to be cost neutral, and potentially a slowed rate of growth of total health care costs.

Operational details of proposed solution
The division will utilize funding for this proposal to hire two contractors to support the implementation of aligned primary care and maternal care APMs in the commercial market. One contractor will provide technical support to carriers, building on the success of the Colorado MPC model. A second contractor will develop an evaluation plan to evaluate the implementation and impact of the APMs, with a focus on the commercial market.

The division feels the retention of an independent contractor is the best solution to assist payers with the implementation of the model because it provides a forum for carriers to discuss sensitive issues they may be unwilling to share in the presence of a regulator, or in a multi-stakeholder context such as the PCPRC. Ongoing communication between the contractor and the PCPRC will maintain that group's role in making recommendations around how primary care investments can be most effectively focused.

Performance metrics, how they will be measured, and anticipated ROI
The performance metrics for the implementation of this proposal, and how they will be measured have yet to be determined, as does the ROI. The division's implementation of the primary care and maternal care APMs will take place largely through contractor support; therefore, performance metrics for the work will be included as part of contract expectations and deliverables.

The division anticipates Bailit Health's work in facilitating the APM Alignment Workgroup and primary care and maternal care subgroups will be completed in March of 2022, which will establish the specific parameters of each APM. The completion of this work, which will necessarily inform the work for the APM technical support contractor and the

evaluation contractor, will allow the division to begin work on the Request for Procurement for each contract in the spring of 2022. This will allow time for the procurement process and selection of vendors by mid-summer, allowing work to begin shortly after the start of FY 2022-23.

Stakeholder perspectives on APMs

During the rulemaking process for Colorado Regulation 4-2-72, the division heard testimony and received written comments from multiple providers in support of APM targets for commercial carriers. Discussions with leadership from the Colorado Academy of Family Physicians and the Colorado Medical Society outside of the context of this budget request indicate interest and support in accelerating Colorado's movement toward APMs.

The rulemaking process for 4-2-72 also gathered feedback from several payer organizations, including the Colorado Association of Health Plans and AHIP, both in oral testimony and written comments, expressing concern about the implementation of APM targets for commercial carriers. Payers on the PCPRC, and those who participated in key informant interviews with Bailit Health, have raised repeated concerns about the ability of large national carriers to participate in regional models that deviate from their current organizational programs and goals. Technical support provided by this state funding will help payers make the modifications necessary to align with Colorado's APM strategy.

Assumptions and Calculations

The division anticipates it will require $250,000 in FY 2022-23 and $250,000 in FY 2023-24 to retain an APM technical support contractor to provide ongoing technical assistance to support commercial payer implementation of aligned primary care and maternal care APMs. The division anticipates it will require an additional $150,000 in FY 2023-24 to retain a contractor to design evaluations of the implementation of the primary care and maternal health APMs in the commercial insurance market as well as the ongoing impact of the APMs on health care quality and costs. The division is not requesting funding for additional FTE.

Supplemental, 1331 Supplemental or Budget Amendment Criteria

Not applicable.

Department of Regulatory Agencies

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-02 Actuarial Review of Insurance Coverages

Dept. Approval By: 10/25/21

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$237,924**	**$0**
	FTE	95.9	0.0	96.1	0.3	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$237,924	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Division of Insurance, (A) Division of Insurance, (1) Division of Insurance - Personal Services	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$237,924**	**$0**
	FTE	95.9	0.0	96.1	0.3	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$237,924	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Regulatory Agencies Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Regulatory Agencies
Division of Insurance

FY 2022-23 Funding Request

Jared Polis
Governor

Patty Salazar
Executive Director

November 1, 2021

Department Priority: R-02
Request Detail: Actuarial Review of Insurance Coverages

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$6,993,579	$237,924	$237,924
FTE	86.3	0.3	0.3
General Fund	$0	$0	$0
Cash Funds	$6,993,579	$237,924	$237,924
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

This request is for $237,924 in FY 2022-23 from the cash fund for 0.3 FTE and actuarial and consulting support to establish a uniform, evidence-based process to evaluate the costs and benefits of new coverages to private health insurance. Requiring an analysis of the potential costs and benefits of changes to commercial insurance coverage would provide the state critical information about the impacts of such changes to consumers, employers, and the state. This is an ongoing request and represents a 3.4 percent change in the division's personal services budget. The bill would also address the Governor's directive, as set forth in his signing statement on S.B. 21-016 and H.B. 21-1068, that the Commissioner "work with the General Assembly to design a process that will enable [the state] to evaluate the impact of new mandates on the health insurance market and consumers."[1]

[1] Polis. J. (2021). "SB21-016 and HB21-1068 Signing Statement." Letter to Members of the General Assembly. https://drive.google.com/file/d/1nEK30PrwWueQuoJA8YgWmNbgWB46QmOD/view.

Current Program

In 2003, the Colorado General Assembly passed legislation (S.B. 03-068) that created a Commission on Mandated Health Insurance Benefits. The commission was charged with reviewing existing and proposed health benefit mandates for their impact on individuals, employers, and health insurers. The commission was repealed by operation of law on July 1, 2010.

Current law (Section 10-16-103, C.R.S) provides that every person or organization that seeks legislative action which would mandate a health coverage submit a report to the legislative committee of reference addressing "both the social and financial impacts of coverage." It appears this requirement has either not been consistently applied or has not been effective in providing the legislature and interested parties with sufficient cost and benefit information. There is also concern that this process disadvantages certain organizations because of the costs of conducting such a report.

In both the 2020 and 2021 legislative sessions, legislation was introduced to address this issue (S.B. 20-127, S.B. 21-085), but those bills failed to pass. This proposal would establish a process for evaluating the costs and benefits of changes to private insurance coverage, with the intended outcome of providing policymakers with more data to guide their decision making.

Problem or Opportunity

Health insurance is a significant monthly expense for most Coloradans. According to the 2019 Colorado Health Access Survey, nearly nine in 10 uninsured Coloradans cite cost as a reason for not having health insurance. For this reason, it is important to consider the implications of legislative actions that have the potential to increase the cost of health insurance premiums. At the same time, such cost concerns should be balanced against the health benefits and long term savings that new coverages may provide to Coloradans, and particularly to Coloradans who have historically and systemically faced barriers to health, including Black, indigenous and people of color, immigrants, LGBTQ+ Coloradans, and Coloradans with low incomes. Currently, when considering changes to health insurance benefits, there is often not sufficient independent data available to policymakers and stakeholders to evaluate the potential costs and benefits during the decision making process.

This bill addresses the concern that, as changes to insurance benefits are considered, there is no independent data source to evaluate the potential impacts and benefits of new coverage

provisions. This proposal will create a process for an objective, reliable, independent review to be undertaken, considering the impact on health plans and consumers in Colorado.

Proposed Solution

The proposed solution is to enact legislation that would create a process for an objective, independent analysis for a specified number of benefits that are proposed for legislative activity. The legislation would define the parameters for the analysis and establish timelines for the process. The intent is that policymakers would have data in a timely manner as they deliberate legislative proposals. This request is for ongoing resources as it is anticipated that there will be future legislative proposals for changes in coverages.

Statutory changes are required to establish the timeline and parameters for the review process. Ongoing funding, primarily for consulting and actuarial services and data collection, will be needed and the division anticipates it will need 0.3 FTE to manage the program.

Theory of Change	Independent, objective data on costs and benefits of changes in health insurance coverage will allow policymakers to consider the value of those changes and who they impact		
Program Objective	Provide policymakers with better data on the costs and benefits of potential new benefits		
Outputs being measured	Number of health insurance benefits evaluated		
Outcomes being measured	Number of health insurance benefits enacted where the benefits outweigh the impact on premiums and out of pocket costs		
Cost/Benefit ratio	None at this time		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Evaluation will consist of analysis of enacted benefits to determine whether they exceed impact on premiums/out of pocket costs	N/A	N/A
Continuum Level	Step 2		

According to the National Conference of State Legislatures, in 2012, 33 states had state mandate review requirements intended to analyze the cost of new state health coverage

provisions.[2] In California, the California Health Benefits Review Program (CHBRP) responds to requests from the legislature to provide analysis of the medical, financial and public health impact of proposed health insurance benefit mandates. The program can receive up to $2 million dollars in funding from a fee assessed on plans and insurers.[3] Thus far, in 2021, the CHBRP has completed 19 analyses.[4] In Pennsylvania, the Health Care Cost Containment Council is tasked with reviewing proposed or existing mandated health insurance benefits upon request of the legislature. In 2019, the Council received $3.4 million and includes 21 full-time positions.[5] In Massachusetts, the Center for Health Information and Analysis conducts the reviews.[6] These entities have significant budgets and, in some cases, do more than review changes to coverage requirements.

In 2020, the division explored another option for evaluating the costs and benefits of potential new coverage requirements. The division issued a Request for Information and asked interested parties to provide information on the costs and benefits of specified coverages. The division also held a stakeholder meeting to garner additional information. While helpful, the process did not generate significant verifiable data on the actual costs and benefits of adding new coverages. The division believes it would be more efficient to have a process whereby an independent, third party expert can collect and review the data and provide a report to policymakers. However, the proposal suggested for Colorado would not have the ability or capacity to do the type of analysis that takes place in the other states detailed above.

If this request is not approved, it will make it difficult for policymakers and stakeholders to fully evaluate the implications of proposed private insurance coverage changes.

Anticipated Outcomes

The anticipated outcome, if approved, is an objective, independent process that policymakers can rely upon when evaluating legislative proposals that could impact the cost of health insurance coverage for Coloradans.

Assumptions and Calculations

This proposal is based on the following assumptions:

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[2] National Conference of State Legislatures. (2018). "State Insurance Mandates and the ACA Essential Benefits Provisions." https://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx.

[3] "Authorizing Statute: California Health Benefits Review Program, University of California." https://chbrp.org/CHBRP%20authorizing%20statute_2020_FINAL_12142020.pdf.

[4] California Health Benefits Review Program. "Completed Analyses." https://chbrp.org/completed_analyses/index.php

[5] "Pennsylvania Senate Bill 841, House Committee on Appropriations Fiscal Note, April 7, 2020." https://www.legis.state.pa.us/WU01/LI/BI/FN/2019/0/SB0841P1623.pdf.

[6] Center for Health Information and Analysis. "Mandated Benefit Reviews." https://www.chiamass.gov/mandated-benefit-reviews/

- There would be a limit on the number of analyses conducted each year. For purposes of this proposal, the division considered five benefits, all of which could be encompassed in a single bill.
- The division would hire an actuarial firm for the actuarial analysis, and, depending on the legislative language, potentially a consulting firm to assist with any health equity considerations in the analysis.
- The division would hire at most two firms to conduct all analysis that may be needed for a single session, to reduce the administrative burden of managing multiple contracts.
- The contractors will have sufficient notification of the legislative proposals identified for review to conduct a complete analysis without requiring an expedited process.
- The work for this proposal would be primarily undertaken by third party actuaries and consultants.
- Claims data may be needed from an independent source, one of which may be the Colorado All Payers Claim Database (APCD).

Using these assumptions, the division estimates it would need approximately 600 hours (0.3) FTE of an Actuary II annually to manage the contracts with the contracted actuaries and consultants, review deliverables, ensure that the contracted entities have access to the data and information as needed to successfully conduct the required analyses, and coordinate with the legislature to manage requested reviews. The division may also need to seek information from multiple sources, including the carriers, the APCD, or other sources, which could require additional time and resources by the Actuary II in terms of coordinating requests and ensuring it is submitted in a timely manner and in the form and manner needed by the contractors to complete their analysis. This equates to an annual cost of approximately $37,924.

The division estimates an actuarial contractor will need to spend at least 40 hours per each proposed insurance coverage, which may include an analysis of any disproportionate impacts on certain populations, at a rate of $400/hour. Assuming, for purposes of this analysis, that five benefits are evaluated, this equates to an annual cost, per session, of $80,000. The division also estimates a consulting firm will spend at least 30 hours per each benefit at a rate of $300/hour to provide support if a demographic/equity component is included in the legislative requirements. This equates to an annual cost, per session, of $45,000.

The division further estimates that obtaining the claims data from a third party could cost approximately $10,000 per benefit analyzed; if up to five benefits are analyzed, this equates to a total cost of $50,000. In addition, the demographic data that would be required to perform a disproportionate impact analysis and reporting may need to be pulled from different data sources than any claims data. The division anticipates some of this information will be available from publicly accessible sources, which will not require a fee, but access to certain database or file downloads may require charges or fees. Therefore, the division estimates an additional $5,000 would be required to ensure access to the data needed to complete the analyses. In total, this equates to an annual cost of $75,000 for data acquisition ($15,000 per benefit x 5).

Overall, the division estimates annual total cost of $237,924, as follows:

- Division FTE $37,924
- Actuarial Costs $80,000
- Consultant Costs $45,000
- Data Collection $75,000

Expenditure Detail			FY 2022-23		FY 2023-24
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
ACTUARY II	$2,918	0.3	$22,759	0.3	$22,759
PERA			$2,481		$2,481
AED			$1,138		$1,138
SAED			$1,138		$1,138
Medicare			$330		$330
STD			$36		$36
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**0.3**	**$37,924**	**0.3**	**$37,924**
Subtotal Personal Services		0.3	**$37,924**	0.3	**$37,924**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500		$0		$0
Telephone Expenses	$450		$0		$0
PC, One-Time	$2,000		$0	-	$0
Office Furniture, One-Time	$5,000		$0	-	$0
Indirect Costs, if applicable			$0		$0
Leased Space, if applicable	$6,600		$0		$0
Actuarial			$80,000		$80,000
Consultant Costs			$45,000		$45,000
Data Collection			$75,000		$75,000
Subtotal Operating Expenses			**$200,000**		**$200,000**
TOTAL REQUEST		0.3	**$237,924**	0.3	**$237,924**
	General Fund:				
	Cash funds:		*$237,924*		*$237,924*
	Reappropriated Funds:				
	Federal Funds:				

Supplemental, 1331 Supplemental or Budget Amendment Criteria

Not Applicable.

Department of Regulatory Agencies

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-03 Align State Surprise Billing Law with Federal No Surpri

Dept. Approval By: 10.25.21

OSPB Approval By:

___	**Supplemental FY 2021-22**
___	**Budget Amendment FY 2022-23**
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$159,912**	**$0**
	FTE	95.9	0.0	96.1	2.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$159,912	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Division of Insurance, (A) Division of Insurance, (1) Division of Insurance - Personal Services	**Total**	**$8,592,720**	**$0**	**$9,025,893**	**$159,912**	**$0**
	FTE	95.9	0.0	96.1	2.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$8,592,720	$0	$9,007,041	$159,912	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$18,852	$0	$0

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Regulatory Agencies Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Regulatory Agencies
Division of Insurance

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Patty Salazar
Executive Director

Department Priority: R-03
Request Detail: Align State Surprise Billing Law with the Federal No Surprises Act

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$6,993,579	$159,912	$0
FTE	86.3	2.0	0.0
General Fund	$0	$0	$0
Cash Funds	$6,993,579	$159,912	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

The Division of Insurance (division) requests $159,912 for 2.0 term-limited FTE in FY 2022-23 to implement and align state statutory provisions regarding out-of-network billing restrictions and the federal No Surprises Act (NSA). The division anticipates aligning current state law regarding noticing and arbitration processes; potentially other technical changes may be required to conform with the federal law. This request will create consistency in enforcement of balanced billing restrictions and promote health equity. This represents a 2.3% percentage change to the division's personal services budget.

Surprise bills frequently lead to medical debt for individuals and are frequently used by some providers to obtain higher in-network payments, resulting in higher premiums, higher cost sharing for individuals and increased health care expenses overall. These challenges are exacerbated for underserved communities.

Current Program

In 2019, the General Assembly passed H.B. 19-1174 (Out-of-Network Health Care Services). H.B. 19-1174, which took effect on January 1, 2020, protects individuals with health benefit plans regulated by the division from receiving a surprise bill when receiving emergency care from an out-of-network provider or facility, or when receiving non-emergency care at an in-network facility from an out-of-network provider. According to the Kaiser Family Foundation, among privately insured patients, an estimated 1 in 5 emergency claims and 1 in 6 in-network hospitalizations include an out-of-network bill.[1]

H.B. 19-1174 establishes payment methodologies for carriers to use when reimbursing providers or facilities for out-of-network services. The bill also requires insurers, providers and facilities to develop and provide disclosures to consumers about the effects of receiving out-of-network services. Finally, the bill creates an arbitration process for carriers and providers, or carriers and facilities, to use to settle out-of-network billing disputes.

Since 2019, the division has established rules governing data reporting requirements for carriers' out-of-network reimbursements, disclosures for emergency and non-emergency out-of-network services, the payment methodology for non-contracted service agencies that provide emergency ambulance services, and the establishment of a carrier payment arbitration program for out-of-network providers. The division has created an arbitration structure and received requests from providers and facilities for arbitration. In July 2021, the division issued its first legislative report on out-of-network utilization and implementation of H.B. 19-1174 based on 2020 data.

According to the Commonwealth Fund, Colorado is one of 18 states with comprehensive legislation prohibiting out-of-network billing.[2] States have documented the benefits and savings to consumers as a result of surprising billing legislation. New York was one of the first states to pass legislation protecting patients from surprise billing. After the law was implemented, researchers found it reduced out-of-network billing in New York by 34% and reduced in-network emergency department physician payments by 9%.[3] California passed surprise billing legislation in 2017. As a result of the legislation, a recent report from the Brookings Institute, recorded a 17% decline in the share of services delivered out-of-network

[1] KFF. (2021). "Surprise Medical Bills: New Protections for Consumers Take Effect in 2022." https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/.

[2] The Commonwealth Fund. (2021). "State Balance-Billing Protections." https://www.commonwealthfund.org/sites/default/files/2021-03/Hoadley_state_balance_billing_protections_table_02052021.pdf.

[3] Zach Cooper, Fiona Scott Morton, Nathan Shekita. (2018). "Surprise! Out-of-Network Billing for Emergency Care in the United States." National Bureau of Economic Research. https://www.nber.org/system/files/working_papers/w23623/w23623.pdf.

by anesthesiologists, radiologists, pathologists, assistant surgeons, and neonatal perinatal physicians at inpatient hospitals and ambulatory surgical centers in the state.[4]

Problem or Opportunity

In December 2020, Congress passed the No Surprises Act which becomes effective January 1, 2022. Similar to the Colorado law, the federal law prohibits surprise billing for certain out-of-network emergency facility services, and out-of-network services at an in-network facility. Unlike Colorado law, the federal law does not establish reimbursement methodologies for out-of-network providers and facilities, but instead creates an independent dispute resolution (IDR) process for carriers, providers and facilities. While Colorado law also has an IDR process, it is only used if a provider or facility asserts its payment was insufficient.

The federal law and Colorado law also differ in other respects, including protections for air and ground ambulance transports and post stabilization care and which plans are covered (the state law applies to fully insured plans whereas federal law applies to fully insured and self insured plans).

On July 1 2021, the federal government released an interim final rule regarding implementation of the NSA. Those rules cover standards for waiving balance billing protections, cost-sharing protections, calculating payment amounts, requirements for disclosures, and complaints processes. On September 10 and September 30, 2021, the federal government released two additional proposed rules related to NSA implementation. The first additional rule included details about data collection by air ambulance providers and insurers, enforcement of NSA violations, and disclosure of compensation to agents and brokers. The second set of rules related to the independent dispute resolution process, good faith estimates for uninsured individuals and the patient provider dispute resolution process. We anticipate additional regulations from the federal government in 2022.

Given the two laws and the potential confusion for consumers, there is a need for consistent communication among providers, plans, consumers, communities, and consumer advocates to reinforce relevant consumer protections related to surprise bills, reduce health disparities, and promote health equity. As appropriate, the division's goal is to create consistency with this request and maintain the more consumer protective aspects of Colorado state law.

Proposed Solution

[4] Loren Adler, Erin Duffy, Bich Ly, and Erin Trish. (2019). "California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law." Brookings. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/.

The division seeks to align current statutory provisions regarding out-of-network billing restrictions with the federal No Surprises Act. The two laws contain similar provisions, but alignment is needed to ensure consistency and efficient implementation of surprise billing requirements for consumers, providers, and insurers. The alignment will keep provisions of the Colorado law that provide stronger protections for consumers than in the federal legislation. In these cases, the NSA provides deference to State law.

In comparing the federal NSA and State law, the division has identified the following potential areas for harmonization:

- The arbitration process
- Reporting and noticing requirements
- Situations in which the laws apply
- Technical changes to streamline administration for the division and carriers

Theory of Change	Aligning the provisions of state and federal law regarding out-of-network protections to streamline implementation		
Program Objective	Create consistency in enforcement of out-of-network restrictions		
Outputs being measured	Reduce number of out-of-network bills		
Outcomes being measured	Health care savings to consumers		
Cost/Benefit ratio	None at this time		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Evaluation will center on quantifying the number of out-of-network bills and the health care savings to consumers achieved via this request.	N/A	N/A
Continuum Level	Step 3		

Under the NSA, states are tasked with being the primary enforcement regulators for provisions of the bill.[5] If a state fails to enforce, the federal government can step in and impose civil monetary penalties. In 2019, 44% of health plans in Colorado were employer-funded or self-insured plans regulated by the federal government. In the interim rules released on July 1, 2021, the federal government clarified ERISA does not prevent states

[5] Beth Fuchs, Jack Hoadley. (2021). "Summary of the No Surprises Act (H.R. 133, P.L. 116-260)." The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2021-01/Surprise_Billing_Law_Summary_v2_UPDATED_01-19-2021.pdf.

from allowing self-funded ERISA covered-plans to choose to opt in to comply with states law regarding the NSA.

The division requests 2.0 term-limited FTE to set up implementation of the additional provisions of the NSA.

- 1.0 term-limited FTE Policy Advisor II: This position will support setting up the arbitration process and the provider payment methodology confirmation process found in Section 10-16-704, C.R.S. The term-limited FTE will be responsible for creating procedures to ensure the arbitration timelines are met, assigning arbiters for each matter, and tracking the outcomes of arbitrations. The division has seen a significant increase in arbitration claims this year -- to date, over 450 claims have been submitted. Some of these claims have been settled outside of arbitration or withdrawn, but with the NSA, there is a potential for even more claims to be submitted, which will require additional coordination and oversight from the division. Further, provider requests for payment methodology confirmation continue to increase, and require additional staff time to manage. It is expected that these requests will continue to increase in both frequency and complexity, and creating processes for this work will also be a responsibility of this FTE.
- 1.0 term-limited FTE Rate Financial Analyst II: This position will support the rulemaking process to implement new provisions as a result of the NSA and update existing rules. The position will also assist the consumer affairs section with setting up procedures and informational materials to support the increase in consumer complaints that are anticipated.

If this proposal is not passed, insurers, providers and consumers will be unclear on which law applies as different rules will apply depending on whether the coverage is subject to state or federal law. As the federal rules continue to be released, the division will reevaluate the longer term staffing and resource needs related to enforcement and implementation of the NSA. This decision item may require coordination with the DORA Division of Professions and Occupations and the Colorado Department of Public Health and Environment. These entities have enforcement authority over the noticing requirements required in state law.

Anticipated Outcomes

The approval of this decision item will allow the division to meet its obligations to the federal government and more effectively implement the provisions of the NSA. Updating state statute will create consistency in enforcement across Colorado. The approval of term limited FTE will assist the division with the anticipated additional workload as a result of the coordination required between the state and federal laws, including creating procedures and policies related to the arbitration process, updating the out-of-network regulations, and developing materials and procedures for consumers.

Assumptions and Calculations

The division estimates it will require 2.0 FTE to oversee the implementation of the out-of-network billing alignment requirements.

Expenditure Detail				FY 2022-23	FY 2023-24	
Personal Services:						
	Classification Title	Biweekly Salary	FTE		FTE	
	POLICY ADVISOR II	$1,711	1.0	$44,496		$0
	PERA			$4,850		$0
	AED			$2,225		$0
	SAED			$2,225		$0
	Medicare			$645		$0
	STD			$71		$0
	Health-Life-Dental			$10,042		$0
	Subtotal Position 1, 1.0 FTE		**1.0**	**$64,554**		
Personal Services:						
	Classification Title	Biweekly Salary	FTE		FTE	
	RATE/FINANCIAL ANALYST II	$2,285	1.0	$59,400		$0

PERA			$4,850		$0
AED			$2,225		$0
SAED			$2,225		$0
Medicare			$645		$0
STD			$71		$0
Health-Life-Dental			$10,042		$0
Subtotal Position 2, 1.0 FTE		**1.0**	**$79,458**		
Subtotal Personal Services		2.0	**$144,012**		
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	2.0	$1,000		$0
Telephone Expenses	$450	2.0	$900		$0
PC, One-Time	$2,000	2.0	$4,000	-	$0
Office Furniture, One-Time	$5,000	2.0	$10,000	-	$0
Indirect Costs, if applicable			$0		$0
Leased Space, if applicable	$6,600		$0		$0
			$0		$0
			$0		$0
			$0		$0
Subtotal Operating Expenses			**$15,900**		

TOTAL REQUEST		2.0	**$159,912**
	General Fund:		
	Cash funds:		*$159,912*
	Reappropriated Funds:		
	Federal Funds:		

	FY 2022-23	FY 2023-24
PERA	10.90%	
AED	5.00%	
SAED	5.00%	
Medicare	1.45%	
STD	0.16%	
Health-Life-Dental	$10,042	

Supplemental, 1331 Supplemental or Budget Amendment Criteria

Not applicable.

Department of Regulatory Agencies

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-04 Increase EDO Resources

Dept. Approval By: 10.25.21

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,838,388**	**$0**	**$8,076,697**	**$0**	**$0**
	FTE	29.5	0.0	29.5	5.0	5.0
	GF	$19,689	$0	$19,689	$0	$0
	CF	$5,001,118	$0	$5,149,774	($392,392)	($357,392)
	RF	$2,740,909	$0	$2,828,297	$392,392	$357,392
	FF	$76,672	$0	$78,937	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office and Administrative Services, (A) Executive Director's Office and Administrative Services, (1) Executive Director's Office and Administrative Services - Personal Services	**Total**	**$2,672,646**	**$0**	**$2,753,534**	**$352,642**	**$352,642**
	FTE	29.5	0.0	29.5	5.0	5.0
	GF	$16,000	$0	$16,000	$0	$0
	CF	$27,000	$0	$20,500	$0	$0
	RF	$2,629,646	$0	$2,717,034	$352,642	$352,642
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office and Administrative Services, (A) Executive Director's Office and Administrative Services, (1) Executive Director's Office and Administrative Services - Operating Expenses	**Total**	**$210,379**	**$0**	**$210,379**	**$39,750**	**$4,750**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,689	$0	$3,689	$0	$0
	CF	$95,427	$0	$95,427	$0	$0
	RF	$111,263	$0	$111,263	$39,750	$4,750
	FF	$0	$0	$0	$0	$0
02. Division of Banking, (A) Division of Banking, (1) Division of Banking - Indirect Cost Assessment	**Total**	**$360,870**	**$0**	**$372,347**	**($29,026)**	**($26,437)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$360,870	$0	$372,347	($29,026)	($26,437)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
04. Office of Consumer Counsel, (A) Office of Consumer Counsel, (1) Office of Consumer Counsel - Indirect Cost Assessment	**Total**	**$63,152**	**$0**	**$65,160**	**($5,078)**	**($4,625)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$63,152	$0	$65,160	($5,078)	($4,625)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
05. Division of Financial Services, (A) Division of Financial Services, (1) Division of Financial Services - Indirect Cost Assessment	**Total**	**$140,739**	**$0**	**$145,215**	**($11,320)**	**($10,310)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$140,739	$0	$145,215	($11,320)	($10,310)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Division of Insurance, (A) Division of Insurance, (1) Division of Insurance - Indirect Cost Assessment	**Total**	**$862,658**	**$0**	**$890,009**	**($66,417)**	**($60,493)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$825,791	$0	$852,053	($66,417)	($60,493)
	RF	$0	$0	$0	$0	$0
	FF	$36,867	$0	$37,956	$0	$0
07. Public Utilities Commission, (A) Public Utilities Commission, (1) Public Utilities Commission - Indirect Cost Assessment	**Total**	**$975,628**	**$0**	**$1,006,566**	**($75,269)**	**($68,555)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$935,823	$0	$965,585	($75,269)	($68,555)
	RF	$0	$0	$0	$0	$0
	FF	$39,805	$0	$40,981	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
08. Division of Real Estate, (A) Division of Real Estate, (1) Division of Real Estate - Indirect Cost Assessment	**Total**	**$441,164**	**$0**	**$455,194**	**($35,482)**	**($32,317)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$441,164	$0	$455,194	($35,482)	($32,317)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
09. Division of Professions and Occupations, (A) Division of Professions and Occupations, (1) Division of Professions and Occupations - Indirect Cost Assessment	**Total**	**$1,860,347**	**$0**	**$1,919,511**	**($149,627)**	**($136,281)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$1,860,347	$0	$1,919,511	($149,627)	($136,281)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
10. Division of Securities, (A) Division of Professions and Occupations, (1) Division of Professions and Occupations - Indirect Cost Assessment	**Total**	**$216,522**	**$0**	**$223,409**	**($17,416)**	**($15,863)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$216,522	$0	$223,409	($17,416)	($15,863)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
11. Division of Conservation, (A) Division of Conservation, (1) Division of Conservation - Indirect Cost Assessment	**Total**	**$34,283**	**$0**	**$35,373**	**($2,757)**	**($2,511)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$34,283	$0	$35,373	($2,757)	($2,511)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Regulatory Agencies Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-04
Request Detail: Increase Resources for Executive Director's Office

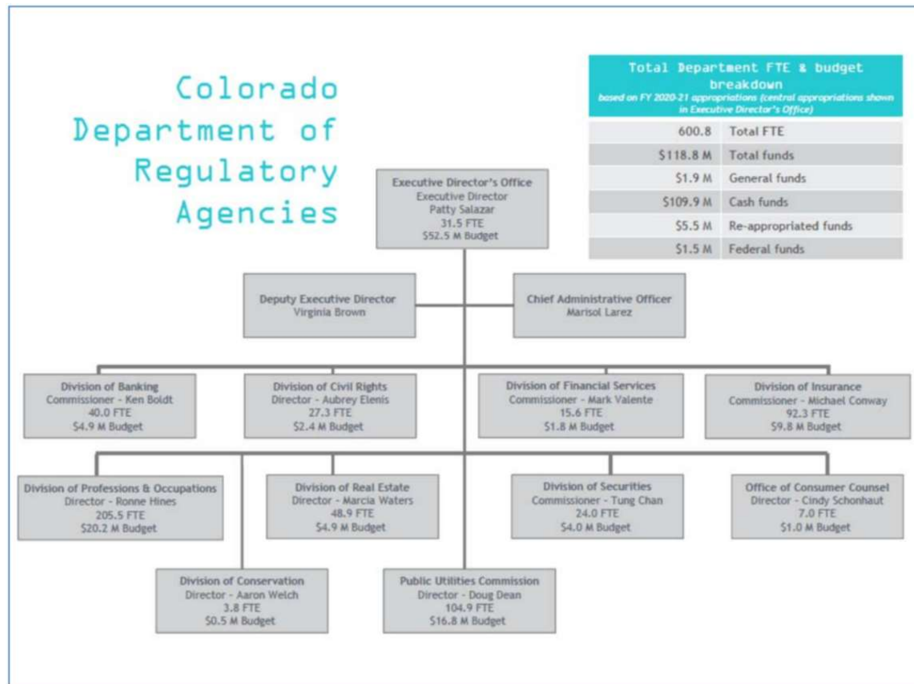
Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$2,629,646	$0	$0
FTE	29.5	5.0	5.0
General Fund	$0	$0	$0
Cash Funds	$0	($392,392)	($357,392)
Reappropriated Funds	$2,629,646	$392,392	$357,392
Federal Funds	$0	$0	$0

Summary of Request

The Department of Regulatory Agencies (DORA or department) requests 5.0 FTE to right-size the Executive Director's Office to address the expanding size and statutory role of the department. This increase is necessary due to significantly increased responsibilities and workload. It will also assist the department with important new initiatives, innovation, and priorities established by the legislature and championed centrally by department leadership. The department proposes a cash fund offset that reduces cash indirect line items in every division in the full amount of the request of $392,392, which should not impact operations.

Current Program

DORA is the state's umbrella regulatory agency, charged with managing licensing and registration for multiple professions and businesses, implementing balanced regulation for Colorado industries, and protecting consumers. The department's 600 employees are dedicated to preserving the integrity of the marketplace and promoting a fair and competitive business environment throughout Colorado.



DORA is comprised of 11 distinct divisions, plus the Executive Director's Office which houses the Broadband Deployment Office and the Colorado Office of Policy, Research and Regulatory Reform. Each division is charged with administering a number of programs, and most house one or more Boards and Commissions made up of appointed members of the public that oversee a large variety of subjects and make a wide range of decisions affecting the day-to-day lives of Coloradans. In total the department is comprised of over 60 programs, over 40 boards having over 330 members.

The Executive Director's Office (EDO) provides oversight, leadership, guidance, and support to DORA's divisions, housing the department's external and administrative functions -- this includes the following offices: Legislative Affairs, Communications, Human Resources, Operations & Process Improvement, Budget, and Accounting. The EDO also maintains oversight over a large number of Type I Department boards and commissions, as well as the Colorado Office of Policy, Research and Regulatory Reform (COPRRR).

There are a number of factors that have increased the breadth and scope of providing these services, among them:

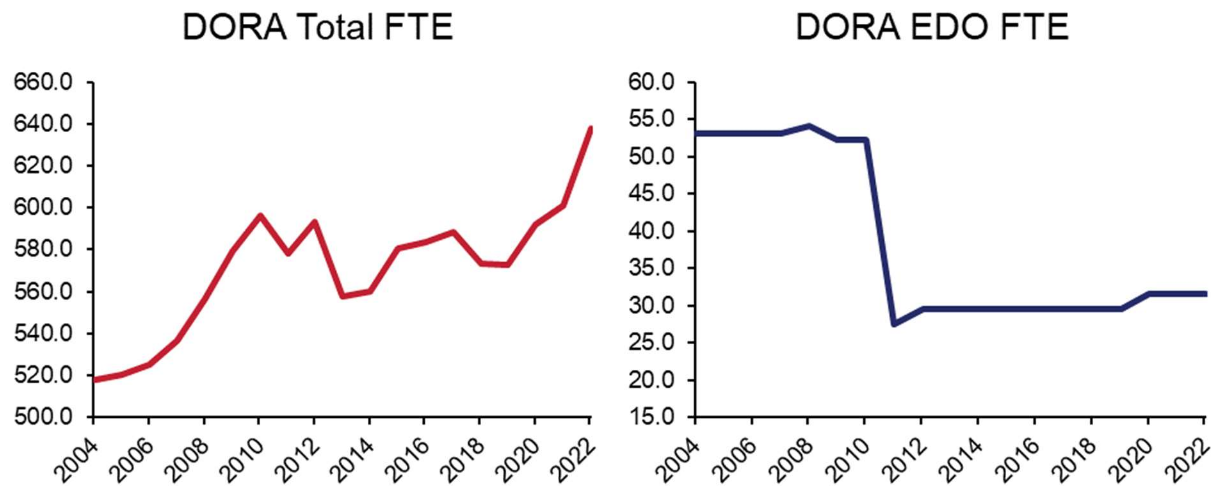
- **Legislative process**: DORA's involvement in the legislative process is significant, receiving over 250 requests for fiscal review per session. It is estimated that DORA is involved in greater than 30% of all legislative bills. Providing critical information in a timely fashion about complex policy workings over so many different programs is a tremendous task at DORA.
- **Colorado Office of Policy, Research and Regulatory Reform (COPRRR)**: The department's responsibility to conduct sunrise and sunset reviews is a large policy responsibility to both the legislative and executive branches of state government. This process itself results in recommendations that involve many bills and reviews, in some cases as many as 30 in a single session. This responsibility is unique in state government, and compounds the bandwidth required for effective policy support of all stakeholders.
- **Boards and Commissions**: Boards and Commissions at DORA are considerable. The department's over 330 volunteer board members would increase the department's size by over 50% if they were not unpaid volunteers, and the need for training, logistical support, and meetings is considerable.
- **Accounting**: DORA's financial structure is complex. Fee sources number in the hundreds and the need to administer an accounting structure that enables the correct revenue to cover the correct expenditures – and ensure that fees are optimal to maintain the department's financial solvency while also adhering to multiple statutory requirements – is both complex and labor-intensive.
- **Operations**: The DORA Operations function manages extensive responsibilities to support the operational infrastructure of the agency, including: the DORA Welcome Center; Citizens Advocate Office; OIT liaison, department IT governance, and business technology oversight; continuous improvement, strategic planning, measurement, and reporting; safety and security assessments; space utilization and renovation projects; suite and badge access; building management liaison; technical training; Executive Director support; and department employee engagement events. Centralized operations planning and execution is an intensive and integral part of ensuring the operational success of the department, particularly given the wide range and disparate purposes of its statutory agencies.
-

Problem or Opportunity

After many years of operating leanly and absorbing significant growth of the organization, the department lacks the administrative bandwidth to perform its necessary responsibilities. At this time, need exists for more transformational endeavors across the spectrum of businesses, processes, policy and legislative responsiveness, and important new realities with respect to labor management.

The lack of EDO resources is best illustrated in two ways: (1) the growth of EDO compared to the divisions it leads and supports, and (2) the relative size of the department's executive resources relative to similar state agencies.

EDO Growth Significantly Lags Growth in the divisions it supports. First, the following visual shows the FTE growth history of the department in total as compared to the Executive Director's Office of over the same period:



This shows that the overhead FTE allocated to the department has been fairly stagnant as program appropriations/FTE have at the same time sharply increased. Incrementally, this has significantly reduced the available staff and bandwidth of support and oversight. In percentage terms, the department's overhead has been reduced from 10.2% of total staff in 2004 (6.1% accounting for the OIT transfer after 2007) to 4.9% in 2022, a level that does not appear to have precedent with organizations of similar size.

DORA lags peer agencies in Executive/Administrative Division size. This comes into sharper focus when the department is compared to agency peers. Utilizing appropriations information for FY 2020-21, the following table shows where DORA

Legislative Bills by Recent Session -- Volume and Appropriations

Legislative Session (Fiscal Year)	Total Bills	Total New Funding	Total New FTE
2016 Session (FY 2016-17)	10	$1,249,311	3.7
2017 Session (FY 2017-18)	6	$187,794	1.2
2018 Session (FY 2018-19)	7	$456,148	1.8
2019 Session (FY 2019-20)	14	$3,742,270	18.9
2020 Session (FY 2020-21)	8	$109,501	0.3
2021 Session (FY 2021-22)	23	$5,335,791	29.8
Total	68	$11,080,815	55.7

stands relative to all agencies at or below 2,000.0 FTE, with similar sized agencies or those thought to be more direct comparisons being highlighted:

FY 2020-21 Appropriations

Department	Total FTE	EDO/Admin FTE	Percent of Total FTE	EDO per LB Division
Treasury	37.90	17.4	45.9%	5.8
State	147.00	21.1	14.4%	5.3
Local Affairs	199.40	14.2	7.1%	3.6
Agriculture	299.50	18.7	6.2%	3.1
Personnel	408.80	37.3	9.1%	5.3
Law	518.00	57.2	11.0%	9.5
Regulatory Agencies	**600.80**	**29.5**	4.9%	**2.7**
Education	609.00	169.9	27.9%	42.5
Labor and Employment	1,290.70	111.2	8.6%	13.9
Public Health and Environment	1,397.00	91.8	6.6%	8.3
Natural Resources	1,511.90	58.6	3.9%	8.4
Revenue	1,592.60	168.5	10.6%	28.1
Public Safety	1,905.80	128.2	6.7%	21.4
Average	**809.1**	**71.0**	**12.5%**	**12.1**

While it is important to note that surface level comparison at the Long Bill level does not represent a nuanced picture, it is just as important to consider that the department's overhead burden is just as multifaceted as many agency peers, with intensive involvement in areas such as legislative policy, peer agency interface, use of legal services, and a massive footprint with respect to citizen involvement (including professionals and consumers alike).

All that said, these numbers indicate that the department is well below the average of agency peers with respect to proportional overhead by total FTE (4.9% vs. 12.5%). This relative size is even more noteworthy as many other departments are more decentralized than DORA, with additional executive/overhead sections within major divisions and business groups to enhance oversight – something that does not generally exist at DORA.

DORA has embraced efficiency in its EDO. In dealing with continual workload increases, the department has both eagerly and of necessity embraced a number of administrative strategies in order to cope with continual increases in responsibility, among them:

- **Virtual Government**. The department has worked diligently and purposefully over the years to increase the availability of virtual government resources (e.g. online licensing and filing services; customer chat functionality; streaming on public meetings, and enhanced resources on the department's public website). These efforts have greatly assisted in an agency that interfaces with 1/5 of the state population as regulated individuals/entities, not to mention a wide net of citizen consumers.
- **Technology**. Implementation of new technology platforms and bolstering employee embrace and ownership of these platforms has also been mission critical for the department. This includes training existing subject matter experts as business technology product owners, establishing internal governance structures, establishing robust internal technical training and on-demand resources to enhance department-wide technical competencies.
- **Optimizing Space Relative to Business Processes and Customer/Public Accessibility**. Managing and configuring our current space to streamline and optimize operations has progressively improved the department's ability to maintain and enhance operational effectiveness. Consolidating divisions into one building provided a foundational first step; however, conceiving of and actualizing the DORA Welcome Center and Conference Suite (completed in 2017) created an immensely valuable "one-stop-shop" to increase customer accessibility to the business services of our 11 divisions, which not only include roughly 600 FTE, but also, over 330 board members across more than 40 boards and 60 regulatory programs who have consistent needs for space for both internal meetings and required public meetings and services. It is often difficult to balance the need for public access with efficient operations and building security, particularly so when programs are continually added without resources to account for this – the DORA Welcome Center and Conference Suite has been a resounding success in this regard.
- **Department Visibility and Customer Service.** In tandem with space planning, the department continually seeks ways in which it might better serve regulated professionals and consumers with any needs they have. The DORA Call Center (which operates within the Welcome Center space) created 7 dedicated, purpose specific phone lines with dedicated staff to field inquiries, connect concerned individuals with the right department entities and staff, and ensure that optimum service is provided by real persons. Furthermore, the Consumer Outreach and Education program continues to raise the department's visibility via outreach and public service media campaigns. Educating professionals and consumers, and being there to answer questions and field concerns, also helps as the department continually grows.

DORA's track record of performance speaks to the success of these strategies. The department has continued to achieve significant administrative successes, successfully implementing new regulatory programs, continuing an optimal audit track record, and

carrying out successful outreach initiatives and campaigns in its mission of consumer protection.

Transformational New Endeavors. Most importantly, continued successful performance amidst such continual growth indicates that additional resources will be put to productive use. A need now exists for transformational endeavors across the spectrum of business processes, policy and legislative responsiveness, and important new realities with respect to labor management. Leveraging past ability to absorb additional administrative work means that new resources can be focused on the following important areas:

1. **Business Innovation**: The Governor has asked OIT to lead and collaborate with agency partners on a statewide, multi-year IT Transformation journey. As noted by OIT IT Transformation extends beyond technology alone. It empowers state agencies to drive IT decisions based on their individual business needs. This involves moving toward a more effective IT model that will align and standardize OIT's service offerings and processes, foster greater collaboration to understand business needs and identify optimal solutions, and empower agencies to drive their strategies through high-impact technology with the support and partnership of OIT. The culmination of this effort will transform statewide IT operations and service delivery with ever-expanding access to secure, virtual government services for ALL Coloradans.
    - Reimagining IT in Colorado will result in three distinct outcomes for state IT operations and service delivery: increased efficiency, transparency, and customer satisfaction.
    - IT Transformation will also yield numerous benefits for agencies and Coloradans, including increasing secure, virtual access to government services and reducing time and cost to conduct business with the state.
2. **Boards and Commissions**: The department is responsible for over 40 boards, commissions, and advisory committees, which are charged with administering over 50 regulatory programs governing professions, occupations, and businesses comprising over 886,000 individual licensees and approximately 65,000 businesses and institutions. DORA has more than 330 board members and over 600 professional regulatory staff. Modernizing the administration and governance of more than 40 boards and commissions within DORA in order to ensure statutory compliance and improved collaboration is a major goal of the department. Ultimately, consistent training, compliance with statutory mandates, and prioritizing the public interest are all achievable results with sufficient resources to devote to this purpose.
3. **Accounting Redundancy and Succession Planning**: Given the continual upward movement in organizational complexity, succession planning in the area of financial recording is necessary to avoid single points of failure, to develop employees with the core skills associated with key roles such as payroll and

procurement, and maintain continuity in this mission critical administrative area.

Proposed Solution

After a year in which $5 million and 38 FTE in new funding were added for FY 2021-22, the department believes the time to address overhead has arrived. However, this problem is also thought to be a tremendous opportunity to bolster department overhead up to reasonable norms so that a premium can also be placed on emerging new priorities.

Right-Size DORA Executive Division Relative to Peer Agencies. For this reason, the department requests the addition of 5.0 FTE, in order to right-size the Executive Director's Office to be within the range of per agencies and closer to averages outlined previously in this request. This increase represents a 17 percent increase to DORA's overhead FTE. Increasing DORA's EDO to 34.5 FTE will elevate DORA's resource conservatively, such that DORA still remains in the lower range of agencies as follows:

FY 2020-21 Appropriations

Department	Total FTE	EDO/Admin FTE	Percent of Total FTE	EDO per LB Division
Treasury	37.90	17.4	45.9%	5.8
State	147.00	21.1	14.4%	5.3
Local Affairs	199.40	14.2	7.1%	3.6
Agriculture	299.50	18.7	6.2%	3.1
Personnel	408.80	37.3	9.1%	5.3
Law	518.00	57.2	11.0%	9.5
Regulatory Agencies	**605.80**	**34.5**	5.7%	**3.1**
Education	609.00	169.9	27.9%	42.5
Labor and Employment	1,290.70	111.2	8.6%	13.9
Public Health and Environment	1,397.00	91.8	6.6%	8.3
Natural Resources	1,511.90	58.6	3.9%	8.4
Revenue	1,592.60	168.5	10.6%	28.1
Public Safety	1,905.80	128.2	6.7%	21.4
Average	**809.5**	**71.4**	**12.6%**	**12.2**

Adding this level of staff to the Executive Director's Office will benefit all aspects of service delivery, workload, inputs, outputs, outcomes, and customers.

Second and more importantly, the department has calculated its request in order to be positioned to place a focus on important priorities, with a focus on specific Wildly Important Goals (WIGs) and alignment with other priorities of the Executive Branch, as follows:

1. <u>Business Innovation:</u> With respect to Business Innovation, the department envisions **2.0 Analyst III positions** tasked primarily in the area of DORA Business Technology and operations service delivery with the goal of increased efficiency, transparency, and customer satisfaction, in alignment with broader efforts across all state agencies under the leadership of the Governor's Office. Ongoing support of secure and virtual access to government services and reducing time and cost to conduct business with the state will be the primary focus across numerous department areas and systems. Business innovation represents an important WIG for the department.
2. <u>Boards and Commissions:</u> The department envisions a **1.0 Technician IV** position to focus on modernizing the administration and governance of more than 40 boards and commissions within DORA in order to ensure statutory compliance and improved collaboration, carrying out consistent training, assisting in ensuring compliance with statutory mandates, and prioritizing the public interest. In particular, having a central resource to carry out initiatives on recruitment and retention of qualified, representative board members, and supporting the board appointment process centrally is a high priority WIG for the department.
3. <u>Collective Bargaining and Labor Relations</u>: For the complex undertaking of managing the formal labor-management partnership between COWINS and the department, and ensuring the fulfillment of specific responsibilities of State agencies outlined in the Colorado Partnership for Quality Jobs and Services Act, the department believes it is necessary to **add 1.0 Analyst III position**. These employees will focus on the administration of statutorily-required partnership agreements and engagement in the collective bargaining process are new responsibilities.
4. <u>Accounting Redundancy and Succession Planning</u>: The department seeks **1.0 Accountant I** positions to provide a base level of resources to continue maintaining base with department transactional complexity. These positions will enable succession planning in the area of financial recording associated with key roles such as payroll and procurement.

Theory of Change	A right-sized executive division will position the department to engage in more transformational endeavors across the spectrum of business processes, policy and legislative responsiveness, and important new realities with respect to labor management.
Program Objective	Engage in transformative business innovation, EDI initiatives, legislative responsiveness, and board and commission modernization. Embrace labor management and succession planning responsibilities.
Outputs being measured	Outputs can include training materials developed, succession plans created, EDI roadmaps, enhanced business processes, labor agreements, and increased representation and expertise in boards/commissions.

Outcomes being measured	n/a		
Cost/Benefit ratio	n/a		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Evaluation would include measurement of outputs listed above	n/a	n/a
Continuum Level	Stage 1		

With respect to the applicability of the evidence continuum/theory of change, the department notes that while this request is designed to right-size oversight of programs that are more directly connected to this style of analysis, Stage 1 may best describe the oversight function prior to development of output/outcome measures for these specific stated objectives. Nevertheless, each of the above-mentioned priorities will be trackable and implemented with an evidenced-based approach, as follows:

1. Business Innovation: Quantified improvements in efficiency, transparency, and customer satisfaction. Quantified enhancements in virtual access to government services and reducing time and cost to conduct business with the state.
2. Boards and Commissions: Reporting on modernization efforts and training. Analysis on public interest improvements.
3. Collective Bargaining and Labor Relations: Fulfillment of specific responsibilities of State agencies outlined in the Colorado Partnership for Quality Jobs and Services Act.
4. Accounting Redundancy and Succession Planning: Reporting on succession planning.

Cash Fund Offset

Additionally, the department proposes reducing the cash indirect line items in every division in the full amount of the request. Reduced cash fund indirect lines would require utilization of the Indirect Cost Excess Recovery Fund, which should not impact operations. The Indirect Cost Excess Recovery Fund currently has a balance of $1.2 million, which should cover the cost of the increase for at least the next three years, without resulting in fee increases.

Offsetting Indirect Cost Amounts by Division

Division	FY 2022-23	FY 2023-24
Banking	(29,026.00)	(26,437.00)
Consumer Advocate	(5,078.00)	(4,625.00)
Insurance	(66,417.00)	(60,493.00)
Financial Services	(11,320.00)	(10,310.00)
Public Utilities Commission	(75,269.00)	(68,555.00)
Real Estate	(35,482.00)	(32,317.00)
Professions and Occupations	(149,627.00)	(136,281.00)
Securities	(17,416.00)	(15,863.00)
Conservation	(2,757.00)	(2,511.00)
Total	**(392,392.00)**	**(357,392.00)**

Anticipated Outcomes

DORA hopes to continue to demonstrate efficient overhead staffing while maintaining a high level of service and responsiveness. The department believes that the 17 percent increase to DORA's overhead proposed in the request will position it to continue its record of administrative success while implementing important new priorities.

With respect to performance metrics, the department proposes a dual approach: continuing to provide data that supports the successful accomplishment of overhead and administration, while also adopting new measurements in the areas targeted by this request, specifically including the areas of Business Innovation, Boards and Commissions, Collective bargaining implementation, and Accounting Redundancy/Succession Planning.

Assumptions and Calculations

Costs were calculated using the FTE template attached to this request and shown below, using position classes identified above and presuming range minimum salaries. Please refer to this table for calculation details.

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($1,410), docking station and monitors ($260), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- Beginning July 1, 2020, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail				FY 2022-23	FY 2023-24	
Personal Services:						
Classification Title	Biweekly Salary	FTE		FTE		
ANALYST III	$1,977	2.0	$102,816	2.0	$102,816	
PERA			$11,207		$11,207	
AED			$5,141		$5,141	
SAED			$5,141		$5,141	
Medicare			$1,491		$1,491	
STD			$165		$165	
Health-Life-Dental			$20,084		$20,084	
Subtotal Position 1 (Bus. Innovation), 2.0 FTE		**2.0**	**$146,045**	**2.0**	**$146,045**	
Classification Title	Biweekly Salary	FTE		FTE		
TECHNICIAN IV	$1,852	1.0	$48,144	1.0	$48,144	
PERA			$5,248		$5,248	
AED			$2,407		$2,407	
SAED			$2,407		$2,407	
Medicare			$698		$698	
STD			$77		$77	
Health-Life-Dental			$10,042		$10,042	
Subtotal Position 4 (Boards), 1.0 FTE		**1.0**	**$69,023**	**1.0**	**$69,023**	
Classification Title	Biweekly Salary	FTE		FTE		
ANALYST III	$1,977	1.0	$51,408	1.0	$51,408	
PERA			$5,603		$5,603	
AED			$2,570		$2,570	
SAED			$2,570		$2,570	
Medicare			$745		$745	

STD			$82		$82
Health-Life-Dental			$10,042		$10,042
Subtotal Position 6 (Labor), 2.0 FTE		**1.0**	**$73,020**	**1.0**	**$73,020**

Classification Title	Biweekly Salary	FTE		FTE	
ACCOUNTANT I	$1,711	1.0	$44,496	1.0	$44,496
PERA			$4,850		$4,850
AED			$2,225		$2,225
SAED			$2,225		$2,225
Medicare			$645		$645
STD			$71		$71
Health-Life-Dental			$10,042		$10,042
Subtotal Position 7 (Accounting), 2.0 FTE		**1.0**	**$64,554**	**1.0**	**$64,554**
Subtotal Personal Services		5.0	**$352,642**	5.0	**$352,642**

Operating Expenses:		FTE		FTE	
Regular FTE Operating Expenses	$500	5.0	$2,500	5.0	$2,500
Telephone Expenses	$450	5.0	$2,250	5.0	$2,250
PC, One-Time	$2,000	5.0	$10,000	-	$0
Office Furniture, One-Time	$5,000	5.0	$25,000	-	$0
Indirect Costs, if applicable			$0		$0
Leased Space, if applicable	$6,600		$0		$0
Other					
Other					
Subtotal Operating Expenses			**$39,750**		**$4,750**

TOTAL REQUEST	5.0	**$392,392**	5.0	**$357,392**
General Fund:				
Cash funds:				
Reappropriated Funds:		*$392,392*		*$357,392*
Federal Funds:				

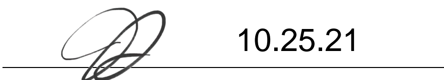
	FY 2022-23	FY 2023-24
PERA	10.90%	10.90%
AED	5.00%	5.00%
SAED	5.00%	5.00%
Medicare	1.45%	1.45%
STD	0.16%	0.16%
Health-Life-Dental	$10,042	$10,04 2

Department of Regulatory Agencies

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-05 Reduce Disabled Telephone Payments Approp

Dept. Approval By:  10.25.21

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$837,350**	**$0**	**$837,350**	**($59,541)**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$837,350	$0	$837,350	($59,541)	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
07. Public Utilities Commission, (A) Public Utilities Commission, (1) Public Utilities Commission - Disabled Telephone Users Fund Payments	**Total**	**$837,350**	**$0**	**$837,350**	**($59,541)**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$837,350	$0	$837,350	($59,541)	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Regulatory Agencies Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-05
Request Detail: Reduce Disabled Telephone Payments

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$837,350	($59,541)	($59,541)
FTE	0.0	0.0	0.0
General Fund	$0	$0	$0
Cash Funds	$837,350	($59,541)	($59,541)
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

The Department of Regulatory Agencies (DORA or department) requests a reduction in the ongoing base appropriation for the Disabled Telephone Users Fund payments, in order to realign appropriated levels with presently expected levels of use for Relay Colorado. Specifically, the Department seeks an ongoing reduction of $59,541 (7.1%) cash funds to the presently appropriated level of $837,750.

Current Program

Enacted in state law in 1992 (.40-17-101, C.R.S), Relay Colorado is a free service that provides full telephone access to people who are deaf, hard of hearing, deaf-blind, or speech-disabled. Relay Colorado allows text-telephone (TTY) users to communicate with regular telephone users through trained relay operators. The operator will dial the requested number and relay the conversation between the two callers. The service is available 24 hours a day, 365 days a year, and there are not any restrictions on the number or length of calls. All calls are confidential and records of conversations are not kept.

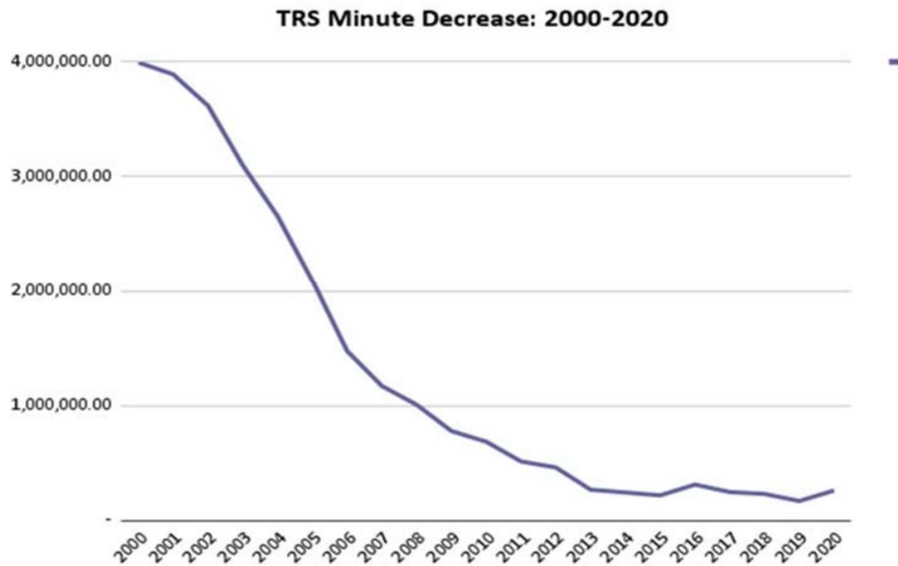
The service was enacted as a state program in 1992 in order to adhere to requirements of the federal Americans with Disabilities Act of 1990 (ADA), which requires that all telecommunications companies in the United States ensure functionally equivalent services for consumers with disabilities. While this requirement technically applies to individual telecommunications carriers (of which there are 35 in Colorado), the State elected to enact a statewide requirement and funding source in order to implement a single contract that satisfies ADA requirements, rather than make the requirement that each individual carrier administer a separate service.

Presently, the cost for contract payments is based on minutes utilized. The contract has resulted in declining expenditures in recent years.

The funding source for the cash fund that supports these payments is a uniform, per month per-access-line surcharge to all business and residential telephone customers including wireless. A substantial decrease in the fee (presently $0.04 per line per month) occurred several years ago in order to reduce fund balance, and HB 16-1414 added wireless subscribers to the base of assessment payers which helps work to maintain nominally low surcharge rates. Increased subsidies to other agencies from this fund resulted in fee levels of roughly $0.06 per line per month effective October 2019.

Problem or Opportunity

Minutes used and costs for this contract have declined considerably for a variety of reasons, the biggest of which is increases in technology which have afforded deaf and hard of hearing individuals increased opportunity to communicate via a wide range of technologies.



Disabled Telephone Users Fund Payments	**FY 16-17**	**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**
Contract Expenditures	$995,583	$961,562	$882,555	$875,499	$777,809
Dollar Change	($283,242)	($34,022)	($79,007)	($7,056)	($97,690)
Percent change	*-22.1%*	*-3.4%*	*-8.2%*	*-0.8%*	*-11.2%*

Several years ago the Department identified a reduction from prior appropriation levels of $1.3 million, reducing the FY 20-21 appropriation to $837,350. It appears that after a further 11.2 percent decline in spending, further room exists for a reduction to present expenditure levels of $777,809.

Proposed Solution

The Department proposes reducing the appropriated line item in alignment with the most recent actual expenses for this program.

Theory of Change	Providing Telephone Relay Services at the statewide level that meets the needs of deaf and hard of hearing consumers as well as complies with the federal Americans with Disabilities Act.
Program Objective	The program makes payments that reflect use of a central statewide Telephone Relay Service contract.
Outputs being measured	Minutes used are tracked and are the basis of contract payments.
Outcomes being measured	Outcomes on the utility of the program are not measured as the statute requires the program to comply with the federal Americans with Disabilities Act.
Cost/Benefit ratio	n/a

Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation		n/a	n/a
Continuum Level	Stage 1		

Anticipated Outcomes

No negative consequences are anticipated for this request, from either an administrative or service delivery standpoint, for several reasons. First, if recent trends hold, contract payments will either plateau at the most recent levels, or potentially continue modest decreases. Second, if for any reason trends do not hold and an unexpected increase occurs, a statutory provision enables the department to record spending authority to cover the excess. As such, the Department is confident that the spending authority reduction is warranted and will not cause unintended negative consequences.

With respect to fees, reduced spending is a factor that contributes to fee reductions, and less spending in this line item does serve to reduce fees albeit incrementally. The most direct impact of this request is to reduce unnecessary spending authority. With a fee assessment of $0.06 per-line-per-month (spread across an estimated 5,800,000 paying lines), this action alone is not likely to result in a calculable, nominal fee change, depending on other appropriations from the fund including pass-through appropriations to other State agencies including the Department of Human Services and the Department of Education. Nevertheless, this request reduces appropriations and reflects reduced spending (which is what affects fees), and so a negative fee impact to the request exists.

Assumptions and Calculations

This request is based on a straightforward, simple calculation that compares the most recent actual years' expenditure (in this case $777,809) with the current appropriated line item ($837,350). The difference between these two figures, $59,541, is the Department's requested reduction.