

# 2017 Medicaid Provider Rate Review Recommendation Report

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**November 1, 2017**

**Submitted to: The Joint Budget Committee and the Medicaid Provider  
Rate Review Advisory Committee**



**COLORADO**

Department of Health Care  
Policy & Financing

## I. Executive Summary

This report contains the work of the Colorado Department of Health Care Policy & Financing (the Department) to review rates paid to providers under the Colorado Medical Assistance Act and contains the Department's findings and recommendations for four broad categories of service: physician services, surgery, anesthesia, and Home- and Community-Based Services (HCBS) Waivers. The rate review process was informed by rate benchmark comparisons, access analyses, stakeholder feedback, and the Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback and recommendations.

### Physician Services and Surgery

The Department found Medicare and most other state Medicaid agencies pay providers differently depending on the place of service; Colorado Medicaid does not. Additionally, access analyses for certain services, in certain areas of the state, were inconclusive. Finally, rate benchmark comparisons widely varied; by category of service, payments varied between 56.76% and 116.75% of the benchmark.<sup>1</sup>

The Department recommends:

1. A payment methodology for physician services and surgeries that differentiates rates based on place of service.
2. For the services and regions where the Department's access analysis was inconclusive, the Department will continue access analysis and utilization monitoring.
3. A budget-neutral rebalancing of certain individual physician service and surgery rates with payments below 80% and above 100% of the benchmark.

### Anesthesia

The Department found payment rates for anesthesia services were 131.64% of the benchmark.

The Department recommends:

4. A reduction in anesthesia service rates to 100% of the benchmark.

### HCBS Waivers

In addition to the Department's access analyses, MPRRAC and stakeholder feedback identified several potential rate-related access barriers for certain services within various waivers. The Department also found that payments for HCBS Waivers varied between 36.70% and 184.58% of the benchmarks.

The Department recommends:

5. Increasing the rate for alternative care facility services .
6. Increasing rates for other waiver services as identified through the ongoing rate setting process, with special attention to services:
  - a. identified by stakeholders through the rate review process; and
  - b. with the biggest gaps between current rates and rates developed via the new rate setting methodology.

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<sup>1</sup> For more information regarding benchmarks, including benchmark descriptions and methodologies, see the 2017 Analysis Report for [Physician Services, Surgery, and Anesthesia](#) (pp.11-13) and the 2017 Analysis Report for [HCBS Waivers](#) (pp.10-12, pp.14-15).



## II. Introduction

### Background

In 2015, the General Assembly adopted Senate Bill 15-228 “Medicaid Provider Rate Review”, which created a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with CRS 25.5-4-401.5, the Department established a rate review process that involves four components:

- assess and, if needed, revise a five-year schedule of rates under review;<sup>2</sup>
- conduct analyses of service, utilization, access, quality, and rate comparisons to an appropriate benchmark for services under review and present the findings in a report published the first of every May;
- develop strategies for responding to the analysis results; and
- provide recommendations on all rates reviewed and present in a report published the first of every November.

In accordance with the statute, the Department also established the MPRRAC, which assists the Department in the review of provider rate reimbursements.

Services under review this year, year two of the five-year rate review process, include:

Category of Service	Sub-Category of Service
Physician Services	<ul style="list-style-type: none"> <li>• Ophthalmology</li> <li>• Speech Therapy</li> <li>• Cardiology</li> <li>• Cognitive Capabilities Assessment</li> <li>• Vascular</li> <li>• Respiratory</li> <li>• Ear, Nose, and Throat</li> <li>• Gastroenterology</li> </ul>
Surgery	<ul style="list-style-type: none"> <li>• Digestive Systems</li> <li>• Musculoskeletal Systems</li> <li>• Cardiovascular Systems</li> <li>• Integumentary Systems</li> <li>• Eye and Auditory Systems</li> <li>• Respiratory Systems</li> </ul>
Anesthesia	
Home- and Community-Based Services (HCBS) Waivers	<ul style="list-style-type: none"> <li>• Waiver for Persons Who are Elderly, Blind, and Disabled (EBD Waiver)</li> <li>• Community Mental Health Supports Waiver (CMHS Waiver)</li> <li>• Waiver for Persons with Brain Injury (BI Waiver)</li> <li>• Waiver for Persons with Spinal Cord Injury (SCI Waiver)</li> <li>• Children’s HCBS Waiver (CHCBS Waiver)</li> <li>• Waiver for Children with Autism (CWA Waiver)</li> <li>• Waiver for Children with Life-Limiting Illness (CLLI Waiver)</li> <li>• Children’s Extensive Supports Waiver (CES Waiver)</li> <li>• Children’s Habilitation Residential Program Waiver (CHRP Waiver)</li> <li>• Waiver for Persons with Developmental Disabilities (DD Waiver)</li> <li>• Supported Living Supports Waiver (SLS Waiver)</li> </ul>

Table 1 - Services under review in year two of the rate review process.

<sup>2</sup> The Department received approval from the Joint Budget Committee to exclude certain rates from the rate review process. Rates were generally excluded when: rates are based on costs; there is an established process delineated in statute or regulation for rate updates; rates are a part of a managed care plan; or payments are unrelated to a specific service rate. For more information see the [Medicaid Provider Rate Review Schedule](#).



On May 1, 2017, the Department published the 2017 Medicaid Provider Rate Review Analysis Report in two parts: [Physician Services, Surgery, and Anesthesia](#) (2017 PSA Analysis Report) and [HCBS Waivers](#) (2017 HCBS Analysis Report).

This document serves as the second report in the annual rate review process. It briefly summarizes what was learned through the rate review process, the Department’s recommendations for services reviewed in year two, and considerations taken in developing recommendations. The Department’s recommendations were informed by the 2017 Analysis Report and MPRRAC and stakeholder feedback, and were developed after working with the Office of State Planning and Budgeting to determine priorities and achievable goals within the statewide budget. This report is intended to be used by the Joint Budget Committee for consideration in formulating the budget for the State Department.

## MPRRAC Guiding Principles

Committee members and the Department share the goal of using the rate review process to critically analyze rates, client access, and provider retention, and develop appropriate recommendations. During year one of the rate review process, the MPRRAC identified a series of overarching guiding principles to guide their evaluation of Department-presented information and their development of recommendations. Those guiding principles were used again during year two:

- “Don’t reinvent the wheel”; if an appropriate rate benchmark or rate setting methodology exists, try to use it.
- Support rates and methodologies that encourage care to be delivered in the least restrictive and least costly environment.
- Develop methodologies to account for the differences in delivering services in geographically different settings, especially rural settings.
- Rates and methodologies should attempt to cover the direct costs of goods and supplies for providers.

## Format of Report

This report is separated into three sections: physician services and surgeries, anesthesia services, and HCBS Waiver services. Each section contains:

- Summary of Findings - a summary of the Department’s findings through the rate review process, which includes rate comparison analyses, access analyses, and MPRRAC and stakeholder feedback.
- Department Recommendations
- Considerations – a summary of the Department’s considerations, which includes information and data that informed the development of the Department’s recommendations. The Department notes where it aligns with MPRRAC recommendations and offers explanations where it does not.<sup>3</sup>

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<sup>3</sup> For the full list of MPRRAC recommendations, see Appendix A – MPRRAC Recommendations.

### III. Year Two Recommendations

#### Physician Services and Surgery

##### Summary of Findings

Research leading up to the [2017 PSA Analysis Report](#) revealed that Medicare, many other state Medicaid agencies, and the Department-administered Child Health Plan Plus program, pay providers differently depending on the place of service. For example, Medicare often pays providers one rate for a service delivered in a non-facility setting, and another rate for the same service delivered in a facility setting. This is different than Colorado Medicaid’s payment methodology, which utilizes a single fee schedule, regardless of place of service. Committee members shared that differential payment by place of service is common practice for private payers.

Additionally, results of the access analyses in the 2017 PSA Analysis Report were inconclusive for six services within six Health Statistics Regions (regions) of the state:<sup>4</sup>

Region	Service
Region 1	Cognitive Capabilities Assessment Services
Region 4	Gastroenterology Services
Region 6	Cognitive Capabilities Assessment Services; and Ear, Nose, and Throat Services
Region 9	Speech Therapy Services; Eye and Auditory Surgeries; and Respiratory Surgeries
Region 10	Gastroenterology Services
Region 11	Respiratory Surgeries

Table 2 - Services with inconclusive access analysis results.

The results of the [2017 PSA Analysis Report](#) also revealed that rate benchmark comparisons varied widely by category of service and by individual service. For example, while one cardiology service payment was 26.37% of the benchmark, another cardiology service payment was 200.64% of the benchmark.<sup>5</sup>

##### Department Recommendations

1. The Department recommends and will pursue a payment methodology for physician services and surgeries that differentiates rates based on place of service.
2. For the services and regions where the Department’s access analysis was inconclusive, the Department will continue access analysis and utilization monitoring, which will be reported in the Department’s Access Monitoring Review Plan, published October 2019.<sup>6</sup> The Department will also communicate results from

<sup>4</sup> Regions were developed by the Health Statistics and Evaluation Branch of the Colorado Department of Public Health and Environment. For more information, refer to the [Colorado Health Data – Health Disparities Profile](#). Colorado is split into 21 regions, with each region containing one or more counties. The regions, and the counties that make up each region, are outlined in the [2017 PSA Analysis Report](#) (pp.8-9).

<sup>5</sup> Information, including visual representations of variations in rate benchmark comparisons, are contained in the [2017 PSA Analysis Report](#).

<sup>6</sup> 42 CFR 447.203, Methods for Assuring Access to Covered Medicaid Services, requires states include within an Access Monitoring Review Plan (AMRP) submitted to the Centers for Medicare & Medicaid Services every three years, an analysis of access to five broad categories of service, and to any services for which the state Medicaid agency has identified possible access

continued analysis and monitoring to Regional Accountable Entities and the Department's Provider Relations Unit to inform other efforts impacting access.

3. The Department will examine individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change, as well as services for which a rate change is appropriate due to changes in medical technology.

Recommendations 1 and 3 align with the Governor's November 1, 2017 executive budget request R-9, "Provider Rate Adjustments".

### Considerations

Recommendation 1 will allow the Department to account for differences in service provision in non-facility and facility settings.<sup>7</sup> It is informed by findings of the [2017 PSA Analysis Report](#) and Department subject matter expert research. It also supports the MPRRAC guiding principle to utilize an existing rate setting methodology where appropriate; in this case a methodology used by Medicare and other state Medicaid agencies. This recommendation also aligns with the MPRRAC's recommendation:

The Department should begin paying for physician services and surgery based on place of service, using Medicare as a model.

Recommendation 2 will ensure continued evaluation of access sufficiency for the aforementioned services. As part of this analysis, the Department will seek to determine whether identified issues are unique to Medicaid.

Recommendation 3 will allow the Department to adjust rates to be reasonably consistent across services, bringing greater alignment to physician services and surgeries without compromising access. It is informed by findings of the [2017 PSA Analysis Report](#) and Department subject matter expert research.

After completing examinations of individual services with payments below 80% and above 100% of the benchmark, the Department may make budget-neutral rebalancing adjustments, within the Department's existing authority. The Department can also make this list of services available for consideration, should additional funds be identified.

Regarding physician services and surgeries, the MPRRAC recommended:

The optimal goal for physician services and surgery rates is parity with Medicare; however, given budgetary constraints, in the short term, the MPRRAC recommends rebalancing rates at the budget-neutral benchmark and then adjust rates to 80% of Medicare.

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issues. Three full time equivalent Department positions were created to undertake this work and will conduct ongoing analysis of access to these services in these regions.

<sup>7</sup> Non-facility rates for physician services and surgeries tend to be higher than facility rates. This is because payments to non-facility locations, such as clinics and offices, account for the overhead costs associated with providing those services. Conversely, payments to facility locations, such as hospitals, are lower because facility locations already receive payments for overhead expenses, in the form of APR-DRG and EAPG payments. More information regarding Medicare's two fee schedules is outlined in the [2017 PSA Analysis Report](#) (pp.11-13).

Committee members stated that their recommendation may not, initially, impact client access, but rather brings logic to rates.<sup>8</sup> While the Department agrees with the MPRRAC that rates should be reasonably consistent across services, the Department does not recommend rebalancing all rates to the budget neutral benchmark (which ranged from 56.76% to 116.72%, depending on the sub-category of service) because: additional analysis would be needed to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that may affect client access and provider retention; and the Department would prefer to complete analysis of the remaining physician services and surgeries before taking broader action.<sup>9</sup> The Department also seeks to avoid resetting all physician services and surgery rates twice, given the commitment to pursuing establishing differential rates based on place of service. The Department may offer additional recommendations next year, when analyses for all physician services and surgeries are complete.

## Anesthesia Services

### Summary of Findings

The results of the [2017 PSA Analysis Report](#) revealed that the Department’s payments for anesthesia services were 131.64% of the benchmark. Unlike payments for physician services and surgeries, all anesthesia service payment for individual anesthesia services were above 100% of the benchmark.<sup>10</sup>

### Department Recommendation

- The Department recommends a reduction in anesthesia service rates to 100% of the rate comparison benchmark, the 2016 Medicare conversion factor, and continued analysis thereafter to evaluate the appropriateness of reimbursement at that level.

If the Department were to reset rates for anesthesia services to 100% of the benchmark, the expected change in expenditure would be:

Estimated Impact of Setting Anesthesia Rates at 100% of 2016 Medicare Conversion Factor				
Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2018-19 Annual Impact	(\$9,728,911)	(\$2,950,535)	(\$274,539)	(\$6,503,837)
FY 2019-20 Annual Impact	(\$10,346,372)	(\$3,205,203)	(\$365,223)	(\$6,775,946)

*Table 3 - Estimated impact of setting anesthesia rates at 100% of 2016 Medicare conversion factor. This would be a one-time adjustment, not a continual adjustment to 100% of the Medicare conversion factor.*

<sup>8</sup> Committee members also posited that logical reimbursement may indirectly allow for providers to accept more Medicaid clients and that such a move would reduce perverse incentives for medical providers to provide certain services over others (see [July 21, 2017 MPRRAC Meeting Minutes](#)).

<sup>9</sup> Approximately 17% percent of physician services and surgeries were reviewed this year; the remaining 83% are scheduled for review next year – year three - of the rate review process.

<sup>10</sup> To identify comparator benchmarks for all services under review in year two, the Department first examined if a service had a corresponding Medicare rate. If a service did not have a corresponding Medicare rate, the Department identified other state Medicaid rates for that same service and calculated an average for that comparison ([2017 PSA Analysis Report](#), pp.11-13). Medicare had a corresponding rate for every anesthesia service benchmark comparison.



Recommendation 4 aligns with the Governor’s November 1, 2017 executive budget request R-9, “Provider Rate Adjustments”.

### Considerations

Recommendation 4 will bring further consistency to rates across services. It is informed by the findings of the [2017 PSA Analysis Report](#) and Department subject matter expert research, and supports the MPRRAC guiding principle to use an existing rate benchmark where appropriate.<sup>11</sup> This recommendation also aligns with the MPRRAC’s recommendation:<sup>12</sup>

The Department should bring anesthesia rates from 131.64% of the benchmark to 100% of the benchmark.

The Department does not believe that reducing anesthesia service rates to 100% of the benchmark will adversely impact client access and provider retention. As required by federal regulation 42 CFR 447.203, should the Department pursue reducing anesthesia rates to 100% of the benchmark, it is required to closely evaluate access to those services for a further three years and report the results within the Access Monitoring Review Plan submitted to CMS in October 2019.<sup>13</sup> This analysis, and others, may suggest that a reduction below 100% of the benchmark is appropriate in the future, to bring further consistency to rates across services, but the Department and the MPRRAC believe an immediate reduction below 100% of the 2016 Medicare conversion factor would be unreasonably large.

The MPRRAC also made a recommendation regarding payment methodology for anesthesia services:

The Department should explore going to a case rate payment for certain obstetrical/labor anesthesia services.<sup>14</sup>

The Department does not currently plan to investigate this recommendation. In April 2017, the Department hosted an Anesthesia Services Benefits Collaborative to discuss proposed policy adjustments to anesthesia services. Prior to that meeting, Department staff researched other state Medicaid agencies’ anesthesia service policies and found only four other states that offer bundled payments for obstetrical anesthesia services. Research did not reveal evidence-based results of better health outcomes for such bundled payments.

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<sup>11</sup> For further information regarding discussions between the MPRRAC and the Department concerning anesthesia services, see Appendix B – Additional Anesthesia Services Considerations.

<sup>12</sup> The Department received feedback from a committee member: that Medicare was not an appropriate benchmark for anesthesia services; and who presented two documents to the MPRRAC and the Department to support this position. Links to those documents, and the Department’s conclusions upon review of those documents, can be found in Appendix B. The MPRRAC voted down an alternative recommendation, that the Department should recalculate the rate benchmark comparison for anesthesia services using a basket of benchmarks that includes market benchmarks. A summary of the discussion leading up to the MPRRAC’s vote is found in the [July 21, 2017 MPRRAC Meeting Minutes](#).

<sup>13</sup> Per 42 CFR 447.203, states must submit an access analysis with any State Plan Amendment that decreases a provider rate or alters a provider payment methodology, prior to securing federal approval of that rate change.

<sup>14</sup> MPRRAC provided specific service codes: CPT 01960, 01961, and 01968.





## HCBS Waiver Services

### Summary of Findings

In the [2017 HCBS Analysis Report](#) the Department noted that utilization information derived from claims data was too limited to allow for robust access analysis ([2017 HCBS Analysis Report](#), pp.15-16). The Department received over 50 written and verbal stakeholder comments regarding potential barriers to accessing services, which were incorporated into the [2017 HCBS Analysis Report](#). Most commonly, stakeholders reported access barriers to: alternative care facility (ACF) services, adult day services, non-medical transportation (NMT) services, personal care and homemaker services, and respite services.

Additionally, the Department recently completed rate setting work for waiver services within the EBD, CMHS, BI, SCI, and CHCBS Waivers. Stakeholder engagement related to the newly developed rate setting methodology began after the publication of the [2017 HCBS Analysis Report](#) and concluded prior to the writing of this report. Though the rate review process and the rate setting process require separate activities and have distinct aims, committee members and stakeholders expressed support for the findings of the rate setting process and stated that both processes should guide Department recommendations.<sup>15</sup>

### Department Recommendations

5. The Department recommends increasing the rate for ACF services.<sup>16</sup>
6. The Department recommends increasing rates for other waiver services as identified through the ongoing rate setting process, with special attention to services:
  - a. identified by stakeholders through the rate review process; and
  - b. with the biggest gaps between current rates and rates developed via the new rate setting methodology.

Recommendation 5 aligns with the Governor’s November 1, 2017 executive budget request R-9, “Provider Rate Adjustments”.

### Considerations

Recommendations 5 and 6 align with the Department’s efforts to ensure, wherever possible, that individuals can receive services within their communities. These recommendations are informed by findings of the [2017 HCBS Analysis Report](#), results of the Department’s rate setting work, and Department subject matter expert research. These recommendations support the MPRRAC guiding principle to encourage care to be delivered in the least-restrictive and least-costly environment.

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<sup>15</sup> For more information regarding differences in the Department’s rate review process and rate setting process, see: [Medicaid Provider Rate Review Schedule](#) (pp.1-2); [Rate Review Process Frequently Asked Questions](#); and [Establishing Provider Payment Rates and Methodologies: A Short Primer](#).

<sup>16</sup> ACF services are defined in 10 CCR 2505-10 section 8.495 as providing an alternative residential option for eligible clients. Services provided in an ACF include: personal care/homemaker services; protective oversight; and medication administration. This service rate does not incorporate room and board. ACF services are available to clients enrolled in the EBD and CMHS Waivers.

Recommendation 5 is supported by results of the [2017 HCBS Analysis Report](#), which showed Colorado's ACF service rates were below other state benchmarks (pp.19-20) and results of the rate setting process, which showed Colorado's ACF service rates were 52.55% of the rate calculated via the Department's new rate setting methodology.<sup>17</sup>

Recommendations 5 and 6 also align with the following MPRRAC recommendation:

The Department should:

- Aim to pay rates that are aligned with the Department's new rate setting methodology, with special attention to services:
  - identified by stakeholders through the rate review process; and
  - with the biggest gaps between current rates and rates developed via the new rate setting methodology.

The MPRRAC offered additional recommendations, that the Department should:

- Continue using robust stakeholder engagement in the new rate setting process.
- Create rates that take client acuity into account.
- Create rates that work towards providing services in the least-restrictive and most cost-effective environment.
- Create rates that take into account which provider types are more subject to economic conditions, such as minimum wage.

The Department will take these recommendations into consideration as it fulfills its ongoing rate setting activities. Specifically, the Department's rate setting process is ongoing and has not yet been completed for CES, DD, and SLS Waivers; additional analysis is estimated to be completed in 2018.

The MPRRAC made an additional, respite-specific, recommendation:

The Department should investigate changing the 24-hour respite unit for in-home respite for all waivers to an hourly unit.

There is no 24-hour unit for in-home respite in the EBD, BI, and SCI Waivers; clients enrolled in these waivers typically cannot receive more than 8 hours of in-home respite per day. Therefore, this recommendation only applies to in-home respite in the CLLI, CES, an SLS Waivers.<sup>18</sup> The Department does not currently plan to perform a specific investigation for this change, but instead will take this recommendation into account when considering general respite service realignment.

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<sup>17</sup> The Department will release more information online regarding results of the new rate setting methodology in the upcoming months.

<sup>18</sup> Further, if the 24-hour unit, also known as day unit, was converted to an hourly unit for clients enrolled in the SLS Waiver, and were the rate for the hourly unit not decreased, clients could potentially see a reduction in the number of services they are eligible to receive, because clients would reach their Service Plan Authorization Limit sooner.

## Appendix A – MPRRAC Recommendations

Below are the MPRRAC's recommendations for services under review in year two of the rate review process. The discussions that precipitated these recommendations can be found in the [MPRRAC Workgroup Meeting Discussion Summary document](#), and the July 21, 2017 and September 15, 2017 MPRRAC Meeting Minutes, found on the Department's [Medicaid Provider Rate Review Advisory Committee website](#).

### Physician Services and Surgery Recommendation

The optimal goal for physician services and surgery rates is parity with Medicare; however, given budgetary constraints, in the short term, the MPRRAC recommends rebalancing rates at the budget-neutral benchmark and then adjust rates to 80% of Medicare. Additionally, the Department should begin paying for physician services and surgery based on place of service, using Medicare as a model.

### Anesthesia Services Recommendation

The Department should bring anesthesia rates from 131.64% of the benchmark to 100% of the benchmark.

The Department should explore going to a case rate payment for certain obstetrical/labor anesthesia services.

### Home- and Community-Based Services (HCBS) Waivers Recommendation

The Department should:

- Aim to pay rates that are aligned with the Department's new rate setting methodology, with special attention to services:
  - identified by stakeholders through the rate review process; and
  - with the biggest gaps between current rates and rates developed via the new rate setting methodology.
- The Department should investigate changing the 24-hour unit for in-home respite for all waivers to an hourly unit.
- Continue using robust stakeholder engagement in the new rate setting process.
- Create rates that take client acuity into account.
- Create rates that work towards providing services in the least-restrictive and most cost-effective environment.
- Create rates that take into account which provider types are more subject to economic conditions, such as minimum wage.

## Appendix B – Additional Anesthesia Services Considerations

The Department received feedback from a committee member that Medicare was not an appropriate benchmark for anesthesia services. During the January 20, 2017 MPRRAC meeting, this committee member presented two documents to the MPRRAC and the Department:

- A report prepared by the U.S. Government Accountability Office titled “[Medicare and Private Payment Differences for Anesthesia Services](#)” (GAO Report) as support that Medicare was not an appropriate benchmark for the anesthesia services rate benchmark comparison.
- A document prepared by the Colorado Society of Anesthesiologists titled “[Addressing the Colorado Medicaid Reimbursement Disparity for Anesthesia Services](#)” (CSA Document), which contained a request for increased anesthesia reimbursement and talking points to support that request.

The Department reviewed these documents and concluded that Medicare was, in fact, an appropriate comparator for anesthesia services. Reasons behind this conclusion include, but are not limited to:

- Age of the GAO Report - The GAO Report was published in 2007, using estimates based on 2002 and 2004 data; Medicare has yet to adjust payments for anesthesia services based on the results of this report.
- The Centers for Medicare and Medicaid Services’ (CMS) Response to the GAO Report – While CMS stated that the GAO Report “provides a good summary of information collected from a variety of sources” (GAO Report, p.31), CMS had “concerns about the limitations of the analysis” (GAO Report, p.32). These concerns included that the list of codes used in the GAO’s analysis did not align with top codes utilized by Medicare clients (the same applies to Colorado Medicaid clients), and that differentials in payments do not necessarily indicate a deficiency; the Department agrees.

