

2019 Medicaid Provider Rate Review Analysis Report

May 1, 2019

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



COLORADO

Department of Health Care
Policy & Financing

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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. Services under review this year, Year Four of the five-year rate review cycle, are listed in the table below.

Rate Review – Year Four Services	
Ambulatory Surgical Centers	Special Connections Program Services
Fee-for-Service Behavioral Health Services	Dialysis and End-Stage Renal Disease Services
Residential Child Care Facilities	Durable Medical Equipment
Psychiatric Residential Treatment Facilities	

This report is intended to be used by the Department, in collaboration with the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and stakeholders, to evaluate findings and generate recommendations, which will be presented in the 2019 Rate Review Recommendation Report November 1, 2019.

This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder feedback, additional research, and conclusion for each service.

For each service grouping, rate benchmark comparisons, which describe (as a percentage) how Colorado Medicaid¹ payments compare to other payers, are listed below.

- Ambulatory Surgical Centers (ASCs): **63.95%**
- Fee-for-Service (FFS) Behavioral Health services: **94.67%**
- Residential Child Care Facilities (RCCFs): **68.56%**
- Psychiatric Residential Treatment Facilities (PRTFs): **114.36%**
- Special Connections Program services ranged from: **9.78% - 630.72%**²
- Dialysis and End-stage Renal Disease (ESRD) services: **83.22%**³
- Durable Medical Equipment (DME): **100.75%**

The Department’s conclusions for each service grouping are summarized below.

- Analyses suggest that ASC payments were sufficient to allow for member access and provider retention. However, planned additional research may reveal more information that could lead to a different conclusion.
- Analyses suggest that FFS behavioral health service payments were sufficient to allow for member access and provider retention.
- Analyses are inconclusive to determine if RCCF payments were sufficient to allow for member access and provider retention.
- Analyses were inconclusive to determine if PRTF payments were sufficient to allow for member access and provider retention.
- Analyses are inconclusive to determine if Special Connections payments were sufficient to allow for member access to provider retention.

¹The consumer-facing name for Colorado Medicaid is Health First Colorado. In this report, the Department refers to the program as Colorado Medicaid.

²This is shown as a range because the services vary within the program. The Department is not able to estimate a weighted average rate benchmark comparison for the Special Connections service grouping at this time due to the lack of available claims data for analysis.

³The dialysis and ESRD facility and professional payments together come to 83.22% of the benchmark.

- Analyses suggest that dialysis and ESRD service payments were sufficient to allow for member access and provider retention.
- Analyses suggest that DME payments for rates not subject to UPL were sufficient to allow for member access and provider retention. Current data suggest that DME rates subject to UPL are sufficient for member access and provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

For certain services, in certain regions, the Department plans to conduct additional research to identify if access issues exist, if they are unique to Colorado Medicaid or Medicaid, and if they are attributable to rates.

While it is important to thoughtfully and critically examine the contents of this report, readers must remember that services reviewed in this year’s report are part of a larger set of services. Services reviewed this year encompass only a subset of all services reviewed over the five-year cycle.

Members of the public are invited to: engage in the rate review process; provide input on access, quality, and provider rates; and attend MPRRAC meetings. The five-year rate review schedule, MPRRAC meeting schedule, past MPRRAC meeting materials, and more can be found on the [Department website](#).

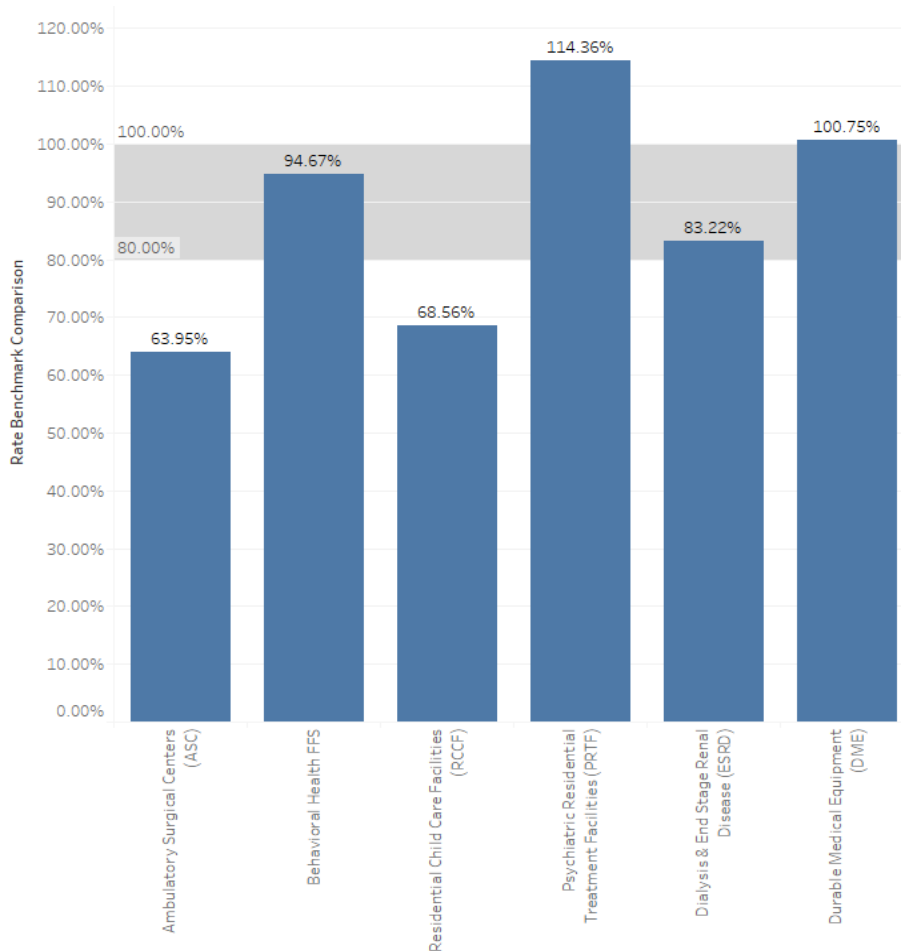


Figure 1. Colorado Medicaid rate benchmark comparison for all Year Four service groupings except Special Connections⁴ (FY 2017-18).

⁴ The Department is not able to estimate a weighted average rate benchmark comparison for the Special Connections service grouping at this time due to the lack of available claims data for analysis.

Introduction

The Department administers the State's public health insurance programs, including Colorado Medicaid, Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. The Department's mission is to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources.

In 2015, the Colorado State Legislature adopted Senate Bill 15-228 "Medicaid Provider Rate Review," an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with [Colorado Revised Statutes \(CRS\) 25.5-4-401.5](#), the Department established a rate review process that involves four components:

- assess and, if needed, review a five-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons 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 them in a report published the first of every November.

The rate review process is advised by the MPRRAC, whose members recommend changes to the five-year schedule, provide input on published reports, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year Four of the five-year rate review cycle, began in November 2018 and included a general discussion of preliminary analyses and stakeholder feedback. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are found on the [Department website](#).

This report contains:

- comparisons of Colorado Medicaid provider rates to those of other payers;
- access to care analyses; and
- assessments of whether payments were sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services, including where additional research is necessary to identify potential access issues.

Payment Philosophy

The rate review process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process, which includes feedback from the MPRRAC, has helped inform the Department's payment philosophy for fee-for-service (FFS) rates.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare; however, there are four primary situations where Medicare may not be an appropriate model when comparing a rate, including, but not limited to:

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., certain DME services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g., RCCFs).

3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar.
4. There is a known issue with Medicare's rates.

When Medicare is not an appropriate comparator, the Department may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While the Department views payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below, must be considered when setting or changing a rate. These include:

- budget constraints that may prevent payments at a certain amount;
- investigating whether a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies;
- identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and
- developing systems to ensure that payments are associated with high-quality provision of services.

When the rate review process indicates a current rate does not align with the Department's payment philosophy, the Department may recommend or implement a rate change. It is also important to note that the Department may not recommend a change, due to the considerations listed above.

Format of Report

Information below explains the sections within each service grouping of the report, including each section's basic structure and content.

Service Description

Service definitions, procedure or revenue codes, and member and provider data are outlined in this section. This section is designed to provide the reader with an understanding of the service grouping under review, as well as the scale of members utilizing and providers delivering this service grouping. For each service grouping, statistics are provided. Those statistics and the fiscal year (FY) they represent are:

- Total Adjusted Expenditures – FY 2017-18⁵
- Total Members Utilizing Services – FY 2017-18
- Year-over-year Change in Members Utilizing Services – FY 2017 and FY 2018⁶
- Total Rendering Providers⁷ – FY 2017-18
- Year-over-year Change in Rendering Providers – FY 2017 and FY 2018⁸

⁵ Total adjusted expenditures may differ from total expenditures as reported in the annual budget due to additional adjustments conducted for this report (e.g., incurred but not reported claims, etc.) and varying service category definitions. For more information, see Appendix B.

⁶ For all services except ASCs and RCCFs, year-over-year change in members was calculated using data from FY 2017 and FY 2018. For ASCs and RCCFs, active provider data from April-June 2017 and April-June 2018 was used.

⁷ A rendering provider is any provider with at least one Colorado Medicaid paid claim in a given month between July 2015-June 2018.

⁸ For all services except ASCs and RCCFs, year-over-year change in providers was calculated using data from FY 2017 and FY 2018. For ASCs and RCCFs, active provider data from April-June 2017 and April-June 2018 was used.

Rate Comparison Analysis

The Department contracted with the actuarial firm Optumas to assist in the comparison of Colorado Medicaid provider rates to those of other payers.⁹ The resulting rate comparison analysis outlined in this section provides a reference point for how Colorado Medicaid reimbursement rates compare to other payers.

Analysis in this section is based on FY 2017-18 administrative claims data and contains a rate benchmark comparison, which describes (as a percentage) how Colorado Medicaid payments compare to other payers. This section also lists the number of procedure codes compared to either Medicare or an average of other states' Medicaid rates, and the range of rate ratios.¹⁰

The Department first examined whether a service had a corresponding Medicare rate to identify comparator rates for analysis. Medicare rates were primarily relied upon for this analysis when available and appropriate. When Medicare rates were unavailable, the Department relied upon other state Medicaid agency rates.¹¹ The Department utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates;
- Medicare's rates, methodologies, and service definitions are generally available to the public;
- Medicare rates are typically updated on a periodic basis; and
- most services covered by Colorado Medicaid are also covered by the Medicare program.

Technical information for all services, except PRTF and Special Connections Program services, is contained in Appendix B.⁹

Access to Care Analysis

The Department contracted with the actuarial firm, Optumas, to assist in evaluating access.¹² The resulting access to care analysis outlined in this section provides a reference point for how well Colorado Medicaid members can access health care services, and if rates are sufficient for provider retention. Access was measured for each of the three county classifications used by the Regional Accountable Entities (RAEs), which are urban, rural, and frontier.¹³

The access to care analysis includes a variety of metrics to capture a broad picture of access to these services by measuring realized access (e.g., penetration rate), potential access (e.g., member-to-provider ratio), and provider availability (e.g., panel size and active providers). It is important to note that these access to care metrics do not

⁹ PRTFs and Special Connections were not included in the Optumas rate comparison analysis due to protected health information (e.g., PRTFs) or the absence of available claims data (e.g., Special Connections).

¹⁰ Definitions for certain terms in this report, such as rate ratio and rate benchmark comparison, are contained in Appendix A.

¹¹ Due to differences in eligible populations, RCCF services were compared to other state Medicaid rates, even though Medicare covers and has rates for these services.

¹² PRTFs and Special Connections were not included in the Optumas access to care analysis due to protected health information (e.g., PRTFs) or the absence of available claims data (e.g., Special Connections).

¹³ County classifications are defined as the following: urban counties are any county in the contractor's service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor's service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor's service area with a population density less than or equal to 6 persons per square mile. Please see Figure 2. Colorado Counties and RAE County Classifications.

indicate how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurance, or to the uninsured population.¹⁴

The five metrics used to analyze access to care for Colorado Medicaid members include:

- Utilizers per provider (panel size) – the average number of members seen per active provider.
- Utilizer density – the total number of distinct utilizers in each county.
- Penetration rate – the estimated percentage of total Colorado Medicaid members in a geographic area (county) that received the service. Comparing the penetration rate across counties helps identify atypical utilization.¹⁵
- Member-to-provider ratio – the total number of Colorado Medicaid members residing in a geographic area compared to the total number of active providers in that geographic area; calculated as providers per 1,000 members. This metric allows for comparison across areas with large differences in population size.
- Drive times – the percentage of service utilizers that live within certain distances from provider locations, represented by drive time bands, using a Geographic Information System (GIS) software application referred to as ArcGIS. The percentage of Colorado Medicaid members is calculated as a percentage of members who utilized the service within each time band listed below:
 - 0 to 30 minutes;
 - 30 to 45 minutes;
 - 45 minutes to an hour;
 - an hour or more.

Access to care metrics are based on FY 2017-18 administrative claims data.^{16,17} More technical information, including details regarding how to read and interpret access to care analysis results, is contained in Appendix B.

Stakeholder Feedback

This section contains summaries of stakeholder comments received during the rate review process.¹⁸

Additional Research

For certain service groupings and regions, particularly when the Department's analysis was inconclusive or indicated a potential access issue, the Department will work to identify other data sources that may be used to conduct additional research. These data sources may be created and maintained as part of the Department's ongoing benefit management and programmatic operations, while others may be created by other organizations or State agencies. The Department plans to use these data sources to conduct further research as the 2019 Medicaid Provider Rate Review Recommendation Report is developed. Options for additional research include:

¹⁴ Please see the Limitations section below for more information regarding this consideration.

¹⁵ A higher penetration rate might indicate that there is a higher concentration of members in need of services relative to other counties; or other factors that impact service utilization in the county, such as drive times, member-to-provider ratios and provider supply, or wait times, amongst other factors.

¹⁶ The utilizers per provider (panel size) metric is based on monthly administrative claims data from July 2015-June 2018.

¹⁷ The Department is working to adopt formal network adequacy standards to reach more meaningful conclusions in future analyses, especially for member-to-provider ratios and drive time metrics.

¹⁸ With permission from stakeholders, the Department posts stakeholder comments on the [Department website](#), except when comments contain protected health information. This report references written comments the Department received September 2017-April 2018. The Department will post additional written comment on the [Department website](#) as it is received. Stakeholders did not provide comment for all service groupings; therefore, some service grouping sections do not summarize stakeholder comments.

- Examining claims and enrollment data to understand if members are accessing services in settings, or via delivery systems, that are excluded from the rate review analysis.
- Referring to research being conducted this year for inclusion in the Department’s [Access Monitoring Review Plan](#).
- Reviewing relevant, regional results on Key Performance Indicators (KPIs), which are tracked as a part of Colorado Medicaid’s delivery system, the Accountable Care Collaborative.
- Reviewing relevant, practice-level results on quality metrics, including Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures.
- Working with the Department’s provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.
- Examining regional and statewide reports and studies published by other agencies, such as the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Conclusion

In accordance with [25.5.-4-401.5, C.R.S.](#), the Department evaluated rate comparison and access to care analyses to determine whether payments are sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services. In this report, conclusions state whether analyses suggest payments were sufficient and where additional research is necessary to identify potential access issues.

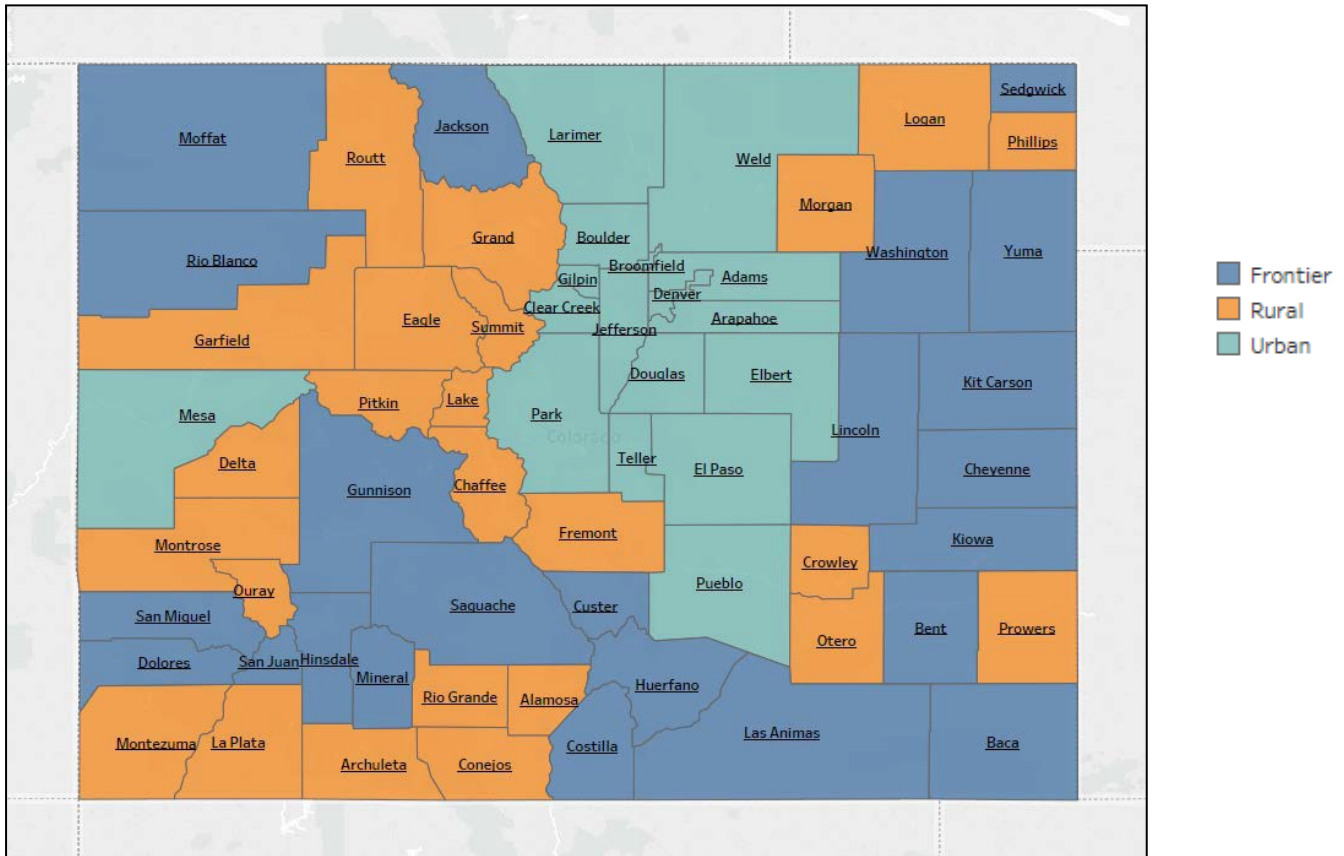


Figure 2. Colorado counties and RAE county classifications.

RAE County Classifications ¹⁹					
Urban		Rural		Frontier	
Adams	Mesa	Alamosa	Logan	Baca	Las Animas
Arapahoe	Park	Archuleta	Montezuma	Bent	Lincoln
Broomfield	Pueblo	Chaffee	Montrose	Cheyenne	Mineral
Boulder	Teller	Conejos	Morgan	Costilla	Moffat
Clear Creek	Weld	Crowley	Otero	Custer	Rio Blanco
Denver		Eagle	Ouray	Dolores	Saguache
Douglas		Delta	Phillips	Gunnison	San Juan
Elbert		Fremont	Pitkin	Hinsdale	San Miguel
El Paso		Garfield	Prowers	Huerfano	Sedgwick
Gilpin		Grand	Rio Grande	Jackson	Washington
Jefferson		Lake	Routt	Kiowa	Yuma
Larimer		La Plata	Summit	Kit Carson	

Table 1. Colorado counties by RAE county classification.

¹⁹ County classifications are defined as the following: urban counties are any county in the contractor’s service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor’s service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor’s service area with a population density less than or equal to 6 persons per square mile.

Limitations

Results from this report and additional research will inform the development of Department recommendations. Still, it is important to note limitations inherent to analyses in this report and limitations that exist generally when evaluating payment sufficiency and access to care.

The access to care analyses and resulting conclusions are based on administrative claims data. Claims-based analyses do not provide information regarding appointment wait times, quality of care, or differences in provider availability and service utilization based on insurance type, nor do claims-based analyses allow for the Department to quantify care that an individual may have needed but did not receive. The Department plans to evaluate other data sources to address this. When the Department evaluates other data sources (mentioned above, in the Format of Report – Additional Research section), there may be assumptions and extrapolations made due to differences in geographic area designations, differences in population definitions, and differences in service definitions. Additionally, many of the access to care indicators are relative, and without defined standards, cannot indicate if all regions are performing well or if all regions are performing poorly. However, these indicators, when analyzed altogether, can help identify regions for focus. For more information, see Appendix B.

There are complicating factors regarding determining rate sufficiency. Member access and provider retention are influenced by factors beyond rates, such as: provider outreach and recruitment strategies; the administrative burden of program participation; health literacy and healthcare system navigation ability; provider scheduling and operational practices; and member characteristics and behaviors.²⁰ Additionally, rates may not be at their optimal level, even when there is no indication of member access or provider retention issues. For example, rates that are above optimal may lead to increases in unwarranted utilization or utilization of low-value services and rates that are less than optimal may lead to decreases in the provision of high-quality care or increases in the provision of services in a less cost-effective setting.

In addition to [25.5-4-401.5, C.R.S.](#), which guides the Department’s rate review process, there are other federal statutes, rules and regulations, as well as Centers for Medicare and Medicaid Services (CMS) regulatory guidance, that guide the Department’s analyses related to member access, provider retention, and payment sufficiency. Given data limitations, which impact how the data can be interpreted, and the increasing need to align the rate review process with other Departmental initiatives and federal regulations, the Department has incorporated changes to the access analysis methodology utilized in the 2019 Rate Review Analysis Report. The changes described in the Format of Report – Access to Care Analysis section, are intended to improve the Department’s ability to apply and interpret data for policy and rate recommendations.

²⁰ The Department adapted some factors from: Long, Sharon 2013. Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State. Accessed via <http://content.healthaffairs.org/content/32/9/1560.full.pdf+html>

Ambulatory Surgical Centers

Service Description

The Ambulatory Surgical Center (ASC) service grouping is comprised of 2,743 procedure codes.²¹

ASC Statistics	
Total Adjusted Expenditures FY 2017-18	\$13,415,406
Total Members Utilizing Services FY 2017-18	20,575
April-June 2018 Over April-June 2017 Change in Members Utilizing Services	2.34%
Total Rendering Providers FY 2017-18	235
April-June 2018 Over April-June 2017 Change in Rendering Providers	9.32%

Table 2. ASC expenditure and utilization data.

Services performed at an ASC are assigned to one of ten rate group brackets for reimbursement. If multiple procedures are provided in a single visit, they are grouped together, and reimbursement is based on the most complex procedure.²² Table 3 (below) shows the ASC code grouping breakdown used in the rate comparison analysis.²³

ASC Code Groupings		
Group Number	Number of Codes	Rate Effective July 1, 2018-June 30, 2019
Group 1	507	\$267.86
Group 2	688	\$358.73
Group 3	696	\$410.26
Group 4	367	\$506.77
Group 5	196	\$576.77
Group 6	8	\$664.45
Group 7	114	\$800.39
Group 8	6	\$782.70
Group 9	68	\$1,077.13
Group 10	8	\$1,786.57

Table 3. ASC code grouping breakdown.

²¹ Utilization data for some of these codes was not available and thus certain codes were not included in the comparison analysis. For more information regarding codes included and excluded in the rate comparison analysis, please see Appendix B.

²² ASC reimbursement includes related services and items, such as use of facilities, nursing services, blood products, and items directly related to the provision of surgical procedures.

²³ For more information on how claims are assigned to each group and for payment methodology, please see Appendix B.



Rate Comparison Analysis

On average, Colorado Medicaid payments for ASCs are estimated at 63.95% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.²⁴

ASC Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$12,339,335	\$19,293,926	63.95%

Table 4. Comparison of Colorado Medicaid ASC service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be \$6,954,591 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 824 procedure codes analyzed in this service grouping, 796 were compared to Medicare rates and 28 procedure code rates were compared to an average of 12 other states' Medicaid rates.²⁵ The ten ASC code grouping rate ratios ranged from 29.71%-139.02%.

²⁴ For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.

²⁵ States used in the ASC rate comparison analysis were Arizona, Nebraska, Wyoming, Alabama, Alaska, Connecticut, Idaho, Indiana, Montana, Nevada, South Dakota, and Texas. For more details on ASC rate comparisons, please see Appendix B.



Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for ASC services averaged 16.50 in April-June 2017 and decreased to 15.78 in April-June 2018. Additionally:

- In urban counties, utilizers per provider averaged 15.57 in April-June 2017 and decreased to 14.89 in April-June 2018.
- In rural counties, utilizers per provider averaged 3.75 in April-June 2017 and decreased to 3.40 in April-June 2018.
- In frontier counties, utilizers per provider averaged 1.99 in April-June 2017 and increased to 2.03 in April-June 2018.

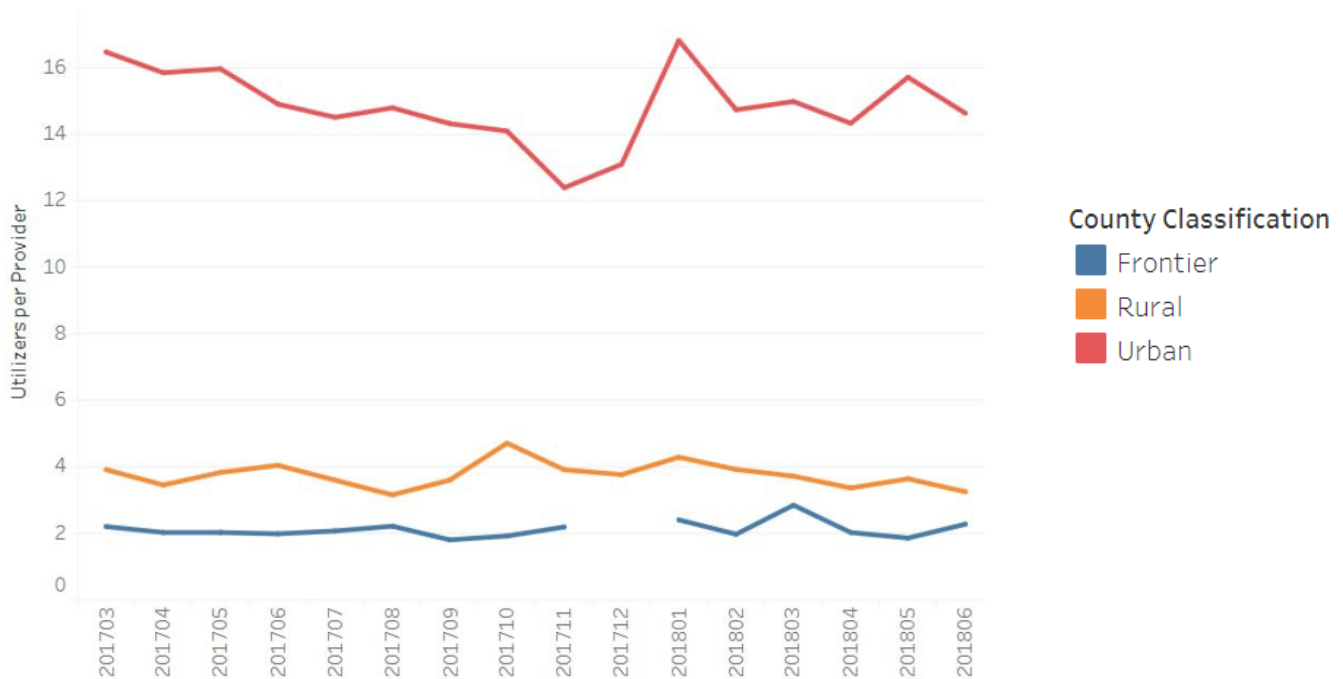


Figure 3. Utilizers per provider (panel size) for ASC services between March 2017 and June 2018.²⁶

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time across all county classifications. The Department did not observe a significant difference between the rate of increased distinct utilizers and active providers, which led to the relatively stable number of utilizers per provider.²⁷

The increases in active providers in the urban counties may indicate improvements in access to care for ASCs in these areas.

²⁶ Some data from the Frontier classification group was blinded for protected health information (PHI), accounting for the gap that appears in the line graph.

²⁷ For data specific to distinct utilizers and active providers, please see Appendix C.

There was a noticeable change November 2017-February 2018 that could be attributed to seasonal utilization patterns.²⁸

Utilizer Density

The utilizer density metric provides information regarding where utilizers of ASC services reside throughout the state. Bent County had the lowest number of utilizers at 34 and El Paso County had highest number of utilizers at 4,286 in FY 2017-18.

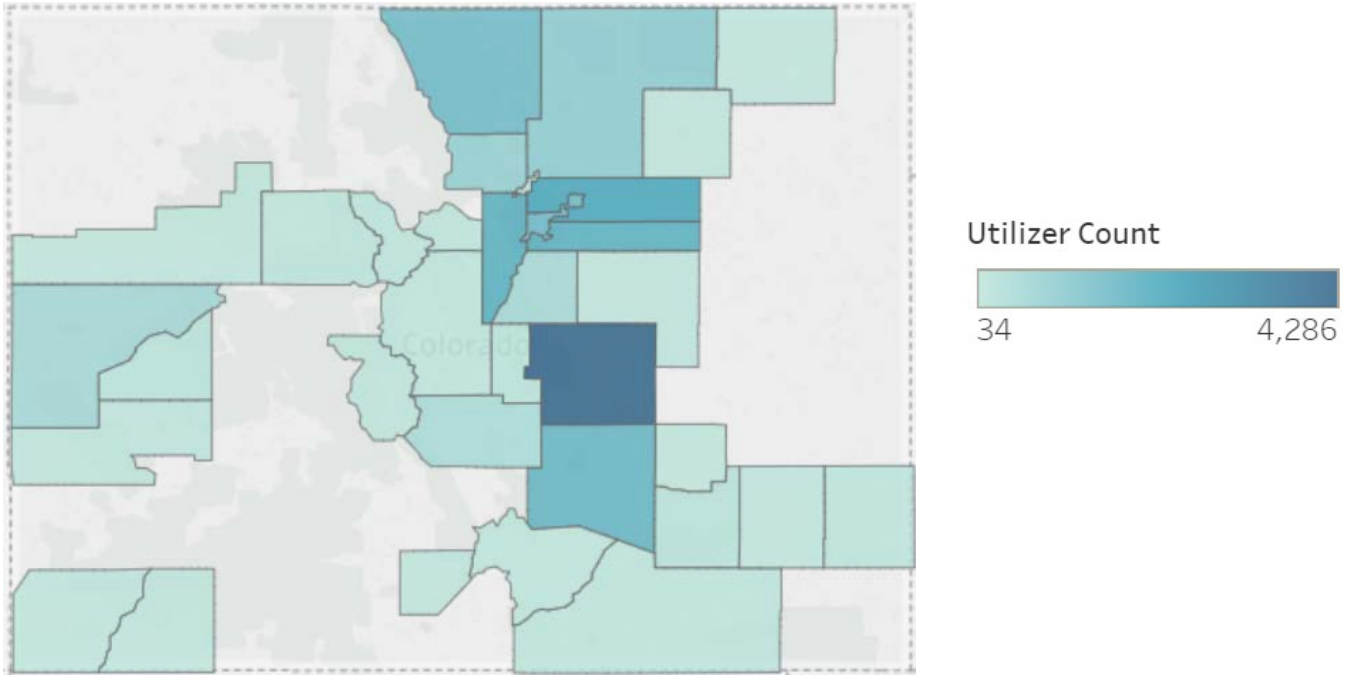


Figure 4. Utilizer density for ASC services by county for FY 2017-18.²⁹

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for ASC services, or a low number of Colorado Medicaid members utilizing ASCs;
- accessing surgical services in other settings not included in this analysis.

Additionally, some counties have been omitted due to protected health information (PHI). For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

²⁸ For more information on which counties were attributed to urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

²⁹ Please see Figure 2. Colorado Counties and RAE County Classifications on page 11 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for ASC services in FY 2017-18 ranged from 0.32% in La Plata County to 2.70% in Fremont County. The penetration rate in Denver County was 0.85%.

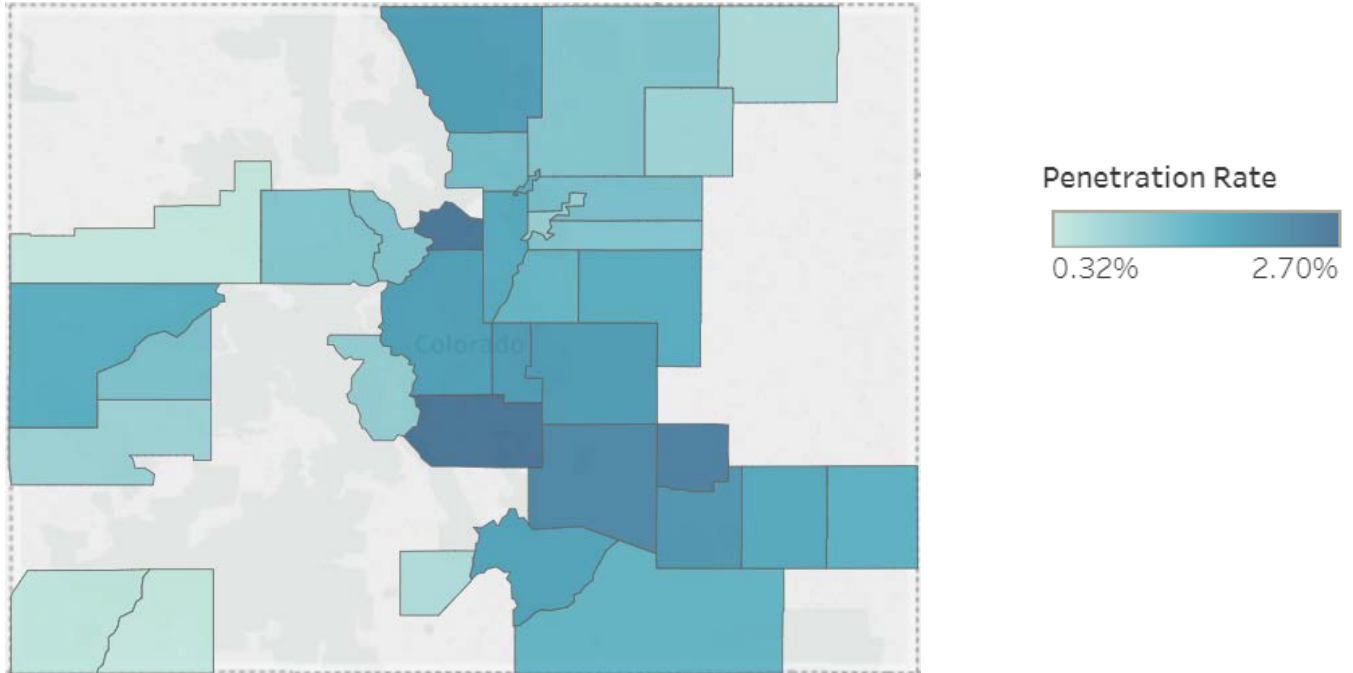


Figure 5. Penetration rates for ASC services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage received ASC services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of active ASC service providers relative to all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

ASC Member-to-Provider Ratios			
Region	FY 2017-18 Providers	FY 2017-18 Members	Providers per 1,000 Members
Frontier	69	41,742	1.65
Rural	112	162,003	0.69
Urban	227	1,217,439	0.19
Statewide	235	1,408,747	0.17

Table 5. Member-to-provider ratio for ASC services expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural and urban counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.³⁰

³⁰ Currently, the Department does not use member-to-provider ratio standards specific to ASC services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department in determining whether the supply of providers is changing over time.



Drive Times

The drive times metric calculates the percentage of ASC utilizers that live within certain drive time bands from where ASC services have been provided.

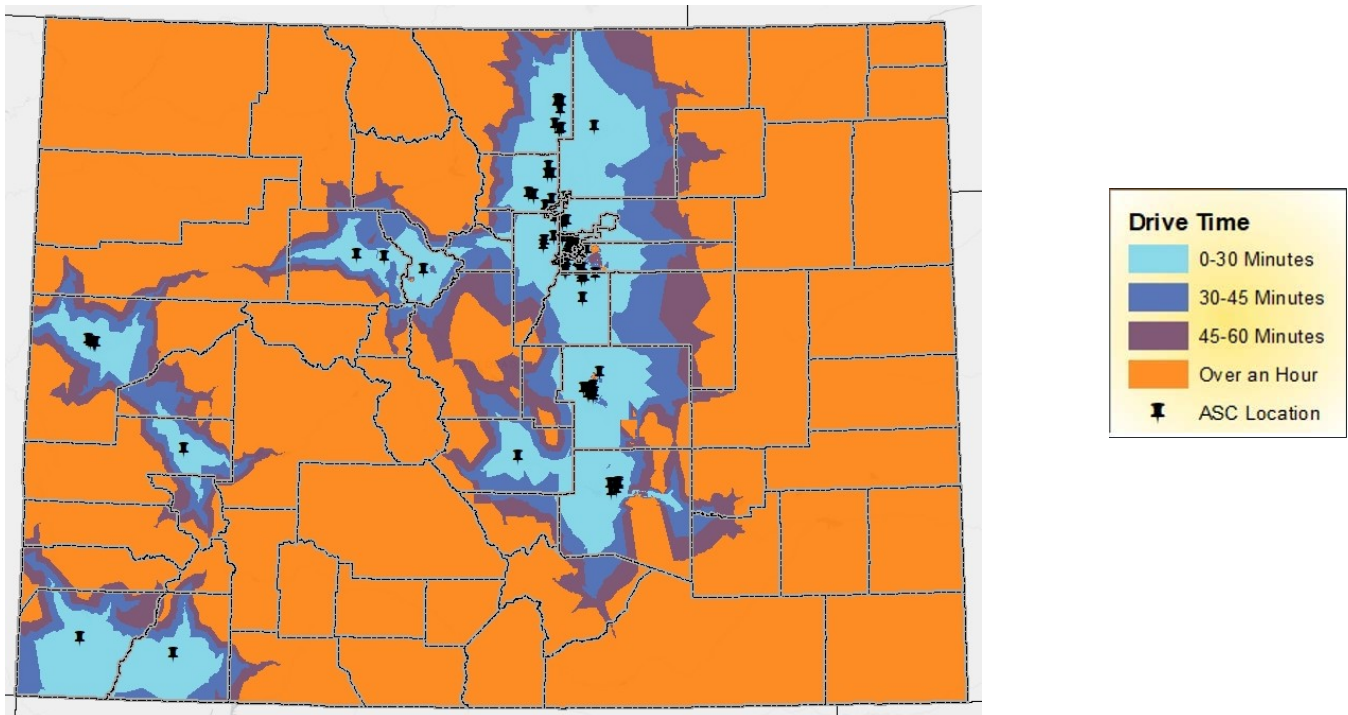


Figure 6. ArcGIS map of drive times for utilizers of ASC services in FY 2017-18.

Overall, 85% of the total utilizers of ASC services in FY 2017-18 needed to travel approximately 30 minutes or less to reach an ASC. Five percent of the total utilizers needed to travel approximately 30-45 minutes; 4% needed to travel approximately 45-60 minutes; and 6% needed to travel over an hour to reach an ASC.

Active ASCs enrolled in Colorado Medicaid tend to be located in more densely populated areas.³¹

Stakeholder Feedback

During the MPRRAC meeting on March 29, 2019, committee members commented that Colorado Medicaid may be able to save funds by reimbursing for more surgical procedures to closer align allowable procedures for ASC Medicaid services with that of ASC Medicare services. Committee members also commented that the Department should consider reimbursing ASCs for all procedures completed in a single visit, rather than only the most complex procedure.

Additional Research

The Department plans to conduct additional research related to noted regional differences, as well as ASC codes covered by Medicare, but not currently covered by Colorado Medicaid in an ASC setting. The Department will also consider the utilization of other services across the continuum of care. The Department also plans to conduct

³¹ This could be due to availability of surgeons or proximity to a hospital site, amongst other factors.

additional research to determine, for example, whether care that could be performed in an ASC is currently being provided in the outpatient hospital setting.

Conclusion

Analyses suggest that ASC payments at 63.95% of the benchmark were sufficient to allow for member access and provider retention. However, additional research may reveal more information that could lead to a different conclusion.

Fee-for-Service Behavioral Health Services

Service Description

The Fee-for-Service (FFS) behavioral health service grouping is comprised of 33 procedure codes. Under a separate managed care arrangement, the Department pays a fixed, capitated rate to the RAEs to manage and reimburse for the vast majority of behavioral health services Colorado Medicaid members receive. Each RAE contracts with behavioral health providers and has flexibility to negotiate reimbursement rates with each of those providers. For services covered under the RAE contracts, behavioral health providers bill the RAEs directly for services rendered.³² Capitated rates reimbursed through the RAEs are not included in the following analysis; only FFS behavioral health rates are included in the analysis.

FFS Behavioral Health Statistics	
Total Adjusted Expenditures FY 2017-18	\$7,973,185
Total Members Utilizing Services FY 2017-18	87,589
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	25.78%
Total Rendering Providers FY 2017-18	2,245
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	17.54%

Table 6. FFS behavioral health services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS behavioral health services are 94.67% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

FFS Behavioral Health Services Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$8,824,473	\$9,321,763	94.67%

Table 7. Comparison of Colorado Medicaid FFS behavioral health service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be \$497,290 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 33 procedure codes analyzed in this service grouping, 25 procedure code rates were compared to Medicare rates and eight procedure code rates were compared to an average of 11 other states' Medicaid rates.³³ Individual FFS behavioral health service rate ratios ranged from 22.71%-231.23%.

³² RAE contracts include a list of covered diagnoses. Where a diagnosis is not part of the RAE contract, providers bill the Department directly for behavioral health services rendered. For example, in FY 2017, 97,000 claims for general psychotherapy services were reimbursed by RAEs, compared to 8,000 claims that were reimbursed FFS. When behavioral health providers bill the Department directly, the Department reimburses providers based on behavioral health service rates listed in the [Colorado Medicaid Fee Schedule](#).

³³ States used in FFS behavioral health rate comparison analysis were Arizona, California, Nebraska, Oklahoma, Oregon, Wyoming, Idaho, Iowa, Louisiana, North Carolina, and Washington. For more details on FFS behavioral health rate comparisons, please see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for FFS behavioral health services averaged 11.06 in FY 2015-16 and decreased to 10.47 in FY 2016-17 and 10.02 in FY 2017-18. Additionally:

- In urban counties, utilizers per provider averaged 10.66 in FY 2015-16 and decreased to 10.26 in FY 2016-17 then decreased to 9.94 in FY 2017-18.
- In rural counties, utilizers per provider averaged 5.24 in FY 2015-16 and decreased to 4.94 in FY 2016-17 then decreased to 4.76 in FY 2017-18.
- In frontier counties, utilizers per provider averaged 1.78 in FY 2015-16 and increased to 1.90 in FY 2016-17 then decreased to 1.75 in FY 2017-18.

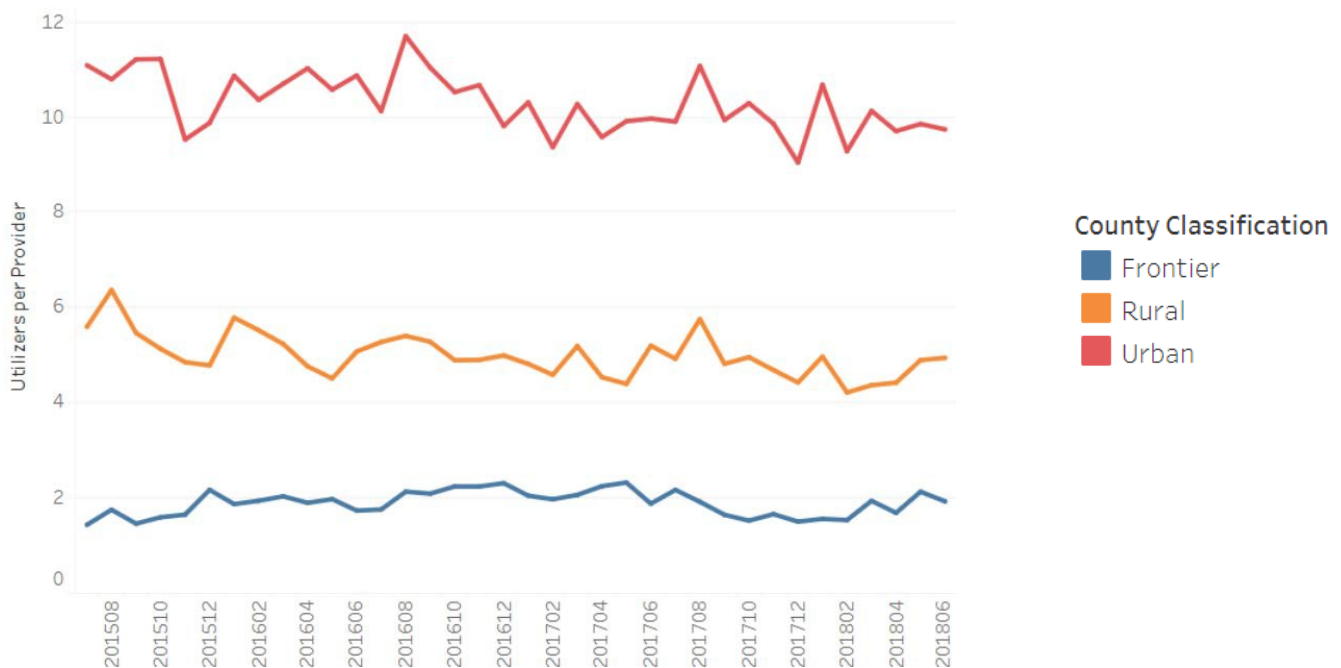


Figure 7. Utilizers per provider (panel size) for FFS behavioral health services between July 2015 and June 2018.

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time across all RAE county classifications. Distinct utilizers increased at a slower rate than active providers, which led to the decrease in the number of utilizers per provider.³⁴

The increases in both the active providers and distinct utilizers in the urban counties may indicate improvements in access to care for FFS behavioral health services in these areas.

The increases in the active providers in the rural counties may indicate improvements in access to care for FFS behavioral health services in these areas.

³⁴ For data specific to distinct utilizers and active providers, please see Appendix C.

The relatively stable number of active providers and distinct utilizers in the frontier counties indicates no change in access to care for FFS behavioral health services in these areas.³⁵

Utilizer Density

The utilizer density metric provides information regarding where utilizers of FFS behavioral health services reside throughout the state. Prowers County had the lowest number of utilizers at 31 and Arapahoe County had the highest number of utilizers at 14,313 in FY 2017-18.

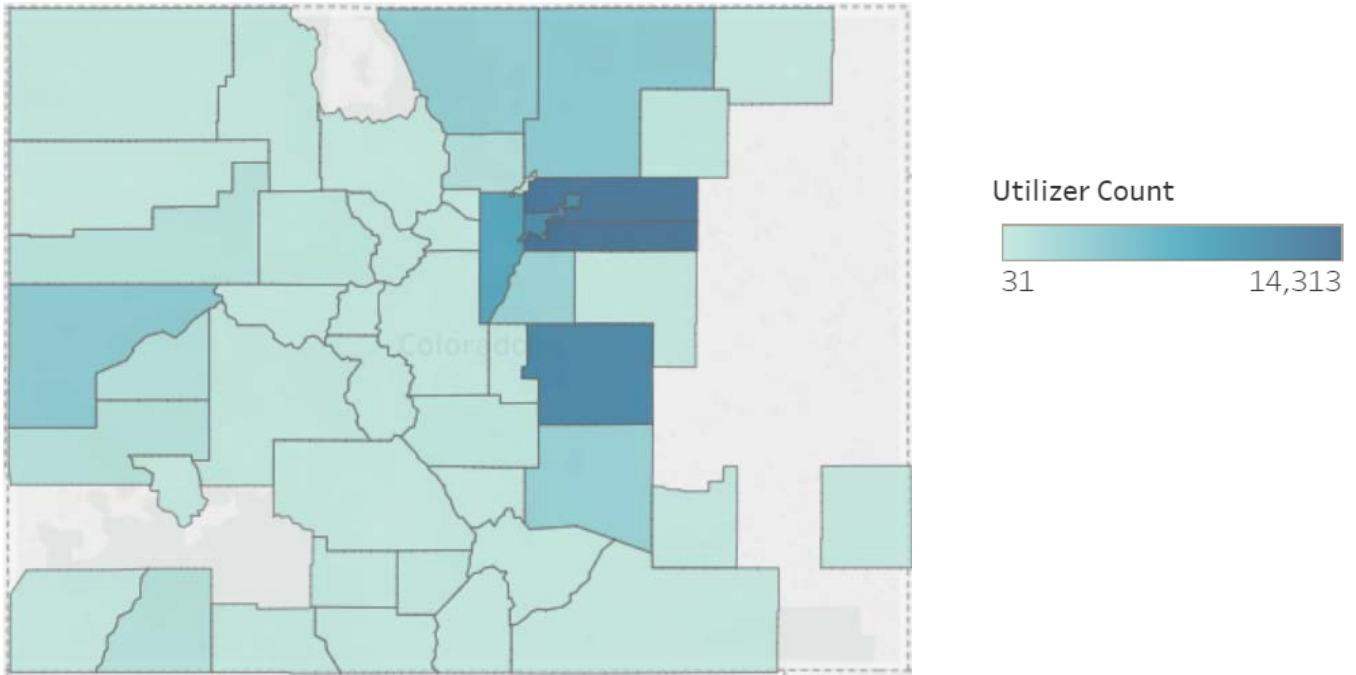


Figure 8. Utilizer density for FFS behavioral health services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for FFS behavioral health services, or a low number of Colorado Medicaid members utilizing FFS behavioral health services;
- utilizers primarily access behavioral health services, particularly adult populations, through the RAEs, which were not included in this analysis.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

³⁵ For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received FFS behavioral health services. Penetration rates for FFS behavioral health services in FY 2017-18 ranged from 0.54% in Prowers County to 11.61% in Mesa County. The penetration rate in Denver County was 6.02%.

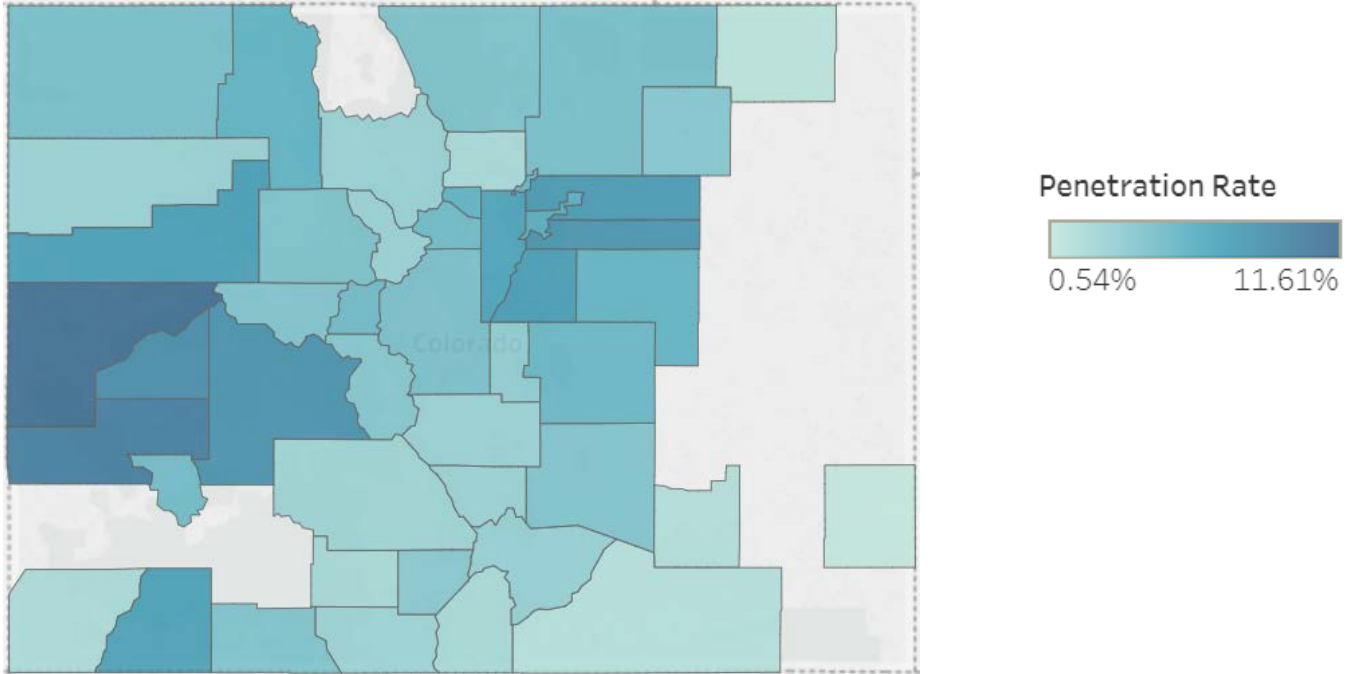


Figure 9. Penetration rates for FFS behavioral health services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving FFS behavioral health services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of FFS behavioral health service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

FFS Behavioral Health Member-to-Provider Ratios			
Region	FY 2017-18 Providers	FY 2017-18 Members	Providers per 1,000 Members
Frontier	307	41,742	7.35
Rural	599	162,003	3.70
Urban	2,097	1,217,439	1.72
Statewide	2,245	1,408,747	1.59

Table 9. Member-to-provider ratio for FFS behavioral health expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.³⁶

³⁶ Currently, the Department does not use member-to-provider ratio standards specific to FFS behavioral health services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of FFS behavioral health services utilizers that live within certain drive time bands from where FFS behavioral health services have been provided.

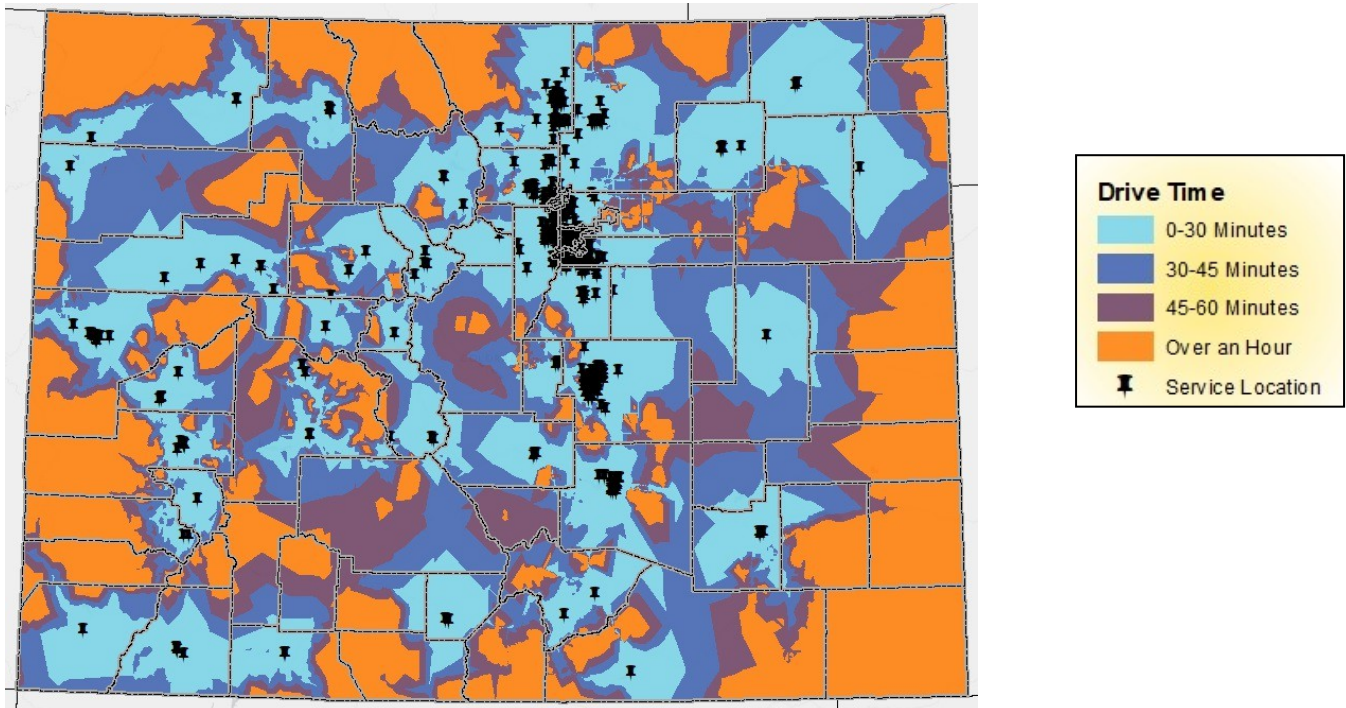


Figure 10. ArcGIS map of drive times for utilizers of FFS behavioral health services in FY 2017-18.

Overall, 96% of the total utilizers of FFS behavioral health services in FY 2017-18 needed to travel approximately 30 minutes or less to reach an FFS behavioral health provider. Additionally, 3% of the total utilizers needed to travel approximately 30-45 minutes; less than 1% of the total utilizers needed to travel approximately 45-60 minutes. Finally, less than 1% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered.

Stakeholder Feedback

The Department did not receive stakeholder feedback on FFS behavioral health services during the rate review process.

Additional Research

The Department plans to conduct additional research related to noted regional differences. The Department will also consider the utilization of other services across the continuum of care.

Conclusion

Analyses suggest that FFS behavioral health payments at 94.67% of the benchmark were sufficient to allow for member access and provider retention.

Residential Child Care Facilities

Service Description

Residential Child Care Facilities (RCCFs) provide residential treatment services for (primarily child welfare-involved) youth.^{37, 38}

The RCCF service grouping is comprised of 16 procedure codes.

RCCF Statistics	
Total Adjusted Expenditures FY 2017-18	\$6,868,228
Total Members Utilizing Services FY 2017-18	1,728
April-June 2018 Over April-June 2017 Change in Members Utilizing Services ³⁹	(11.57%)
Total Rendering Providers FY 2017-18	144
April-June 2018 Over April-June 2017 Change in Rendering Providers	6.67%

Table 10. RCCF services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for RCCFs are 68.56% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.⁴⁰

RCCF Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$8,200,219	\$11,960,022	68.56%

Table 11. Comparison of Colorado Medicaid RCCF service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be \$7,759,803 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. All codes in this service grouping were compared to an average of 10 other states' Medicaid rates.^{41, 42} RCCF individual rate ratios ranged from 47.00%-100.64%.

³⁷ These services are part of a child welfare services continuum; counties place members into an RCCF when other child welfare services (such as group home placement) are inadequate to meet the need. Room and board are funded by the counties. A defined list of services performed in the RCCFs, such as family psychotherapy, is reimbursed by Colorado Medicaid.

³⁸ RCCF services are not included in the RAE capitated behavioral health program.

³⁹ RCCF services were analyzed using claims data from April-June 2017 and April-June 2018.

⁴⁰ For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.

⁴¹ States used in RCCF rate comparison analysis were Arizona, Wyoming, Idaho, Iowa, Oklahoma, Oregon, North Carolina, California, Louisiana, and Washington. For more details on RCCF rate comparisons, please see Appendix B.

⁴² Medicare covers certain RCCF services for individuals under 65 years old who qualify for Medicare due to disability; however, because the population eligible for Medicare RCCF services is considerably different from the population eligible for Colorado Medicaid's RCCF services, the Department compared exclusively to other states' Medicaid rates.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for RCCF services averaged 9.40 April-June 2017 and decreased to 8.13 April-June 2018. Additionally:

- For urban counties, utilizers per provider averaged 8.12 in April-June 2017 and decreased to 6.88 in April-June 2018.
- For rural counties, utilizers per provider averaged 1.85 in April-June 2017 and decreased to 1.50 in April-June 2018.

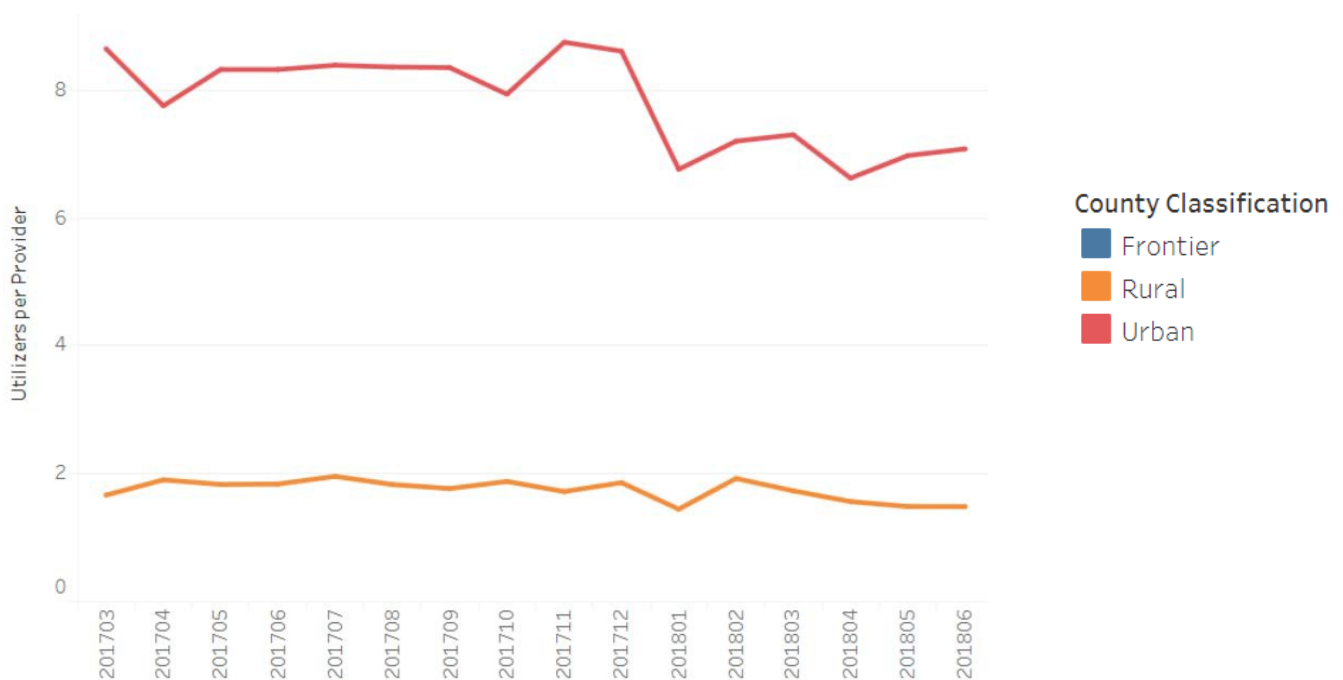


Figure 11. Utilizers per provider (panel size) for RCCF services between March 2017 and June 2018.⁴³

Analysis indicates that there were increases in the number of active providers over this time. Distinct utilizers decreased at a faster rate than the increase in the number of active providers, which led to the decrease in the number of utilizers per provider.⁴⁴

The decreases in distinct utilizers in the urban counties may indicate changes in access to care for RCCF services in these areas.

The increases in the active providers in the rural counties may indicate improvements in access to care for RCCF services in these areas.

The Department is unable to show utilizers per provider information for frontier counties due to PHI. However, the Department intends to use the analysis internally to inform ongoing benefit and program management initiatives.⁴⁵

⁴³ The Department is unable to show utilizers per provider information for frontier counties due to PHI.

⁴⁴ For data specific to distinct utilizers and active providers, please see Appendix C.

⁴⁵ For more information on which counties belong in each urban, rural, and frontier regions, please Figure 2. Colorado Counties and RAE County Classifications on page 11.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of RCCF services reside throughout the state. Boulder County had the lowest number of utilizers at 35 and Denver County had highest number of utilizers at 342 in FY 2017-18.

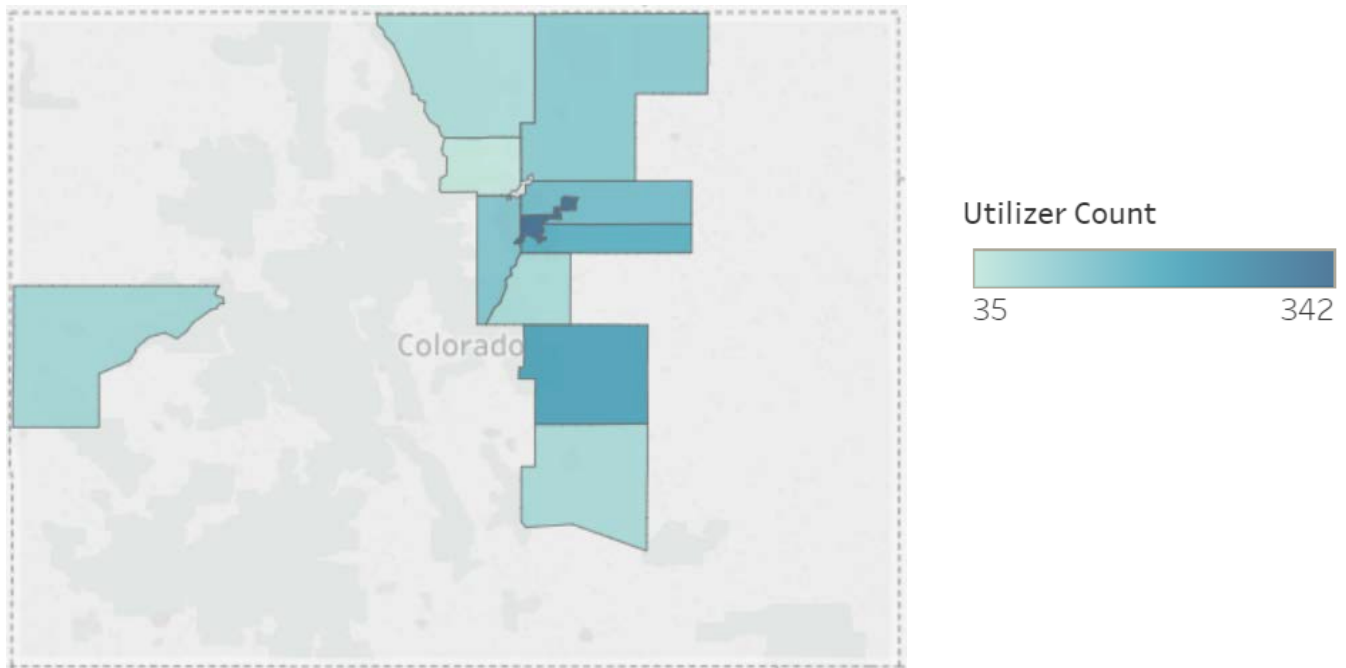


Figure 12. Utilizer Density for RCCF services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for RCCF services, or a low number of Colorado Medicaid members utilizing RCCF services;
- statewide initiatives that support keeping children in home-based settings when possible;
- Colorado Medicaid members receiving RCCF services tend to have a combination of high complexity and comorbid diagnoses that can make placement difficult.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for RCCF services in FY 2017-18 ranged from 0.05% in Boulder County to 0.24% in Mesa County.

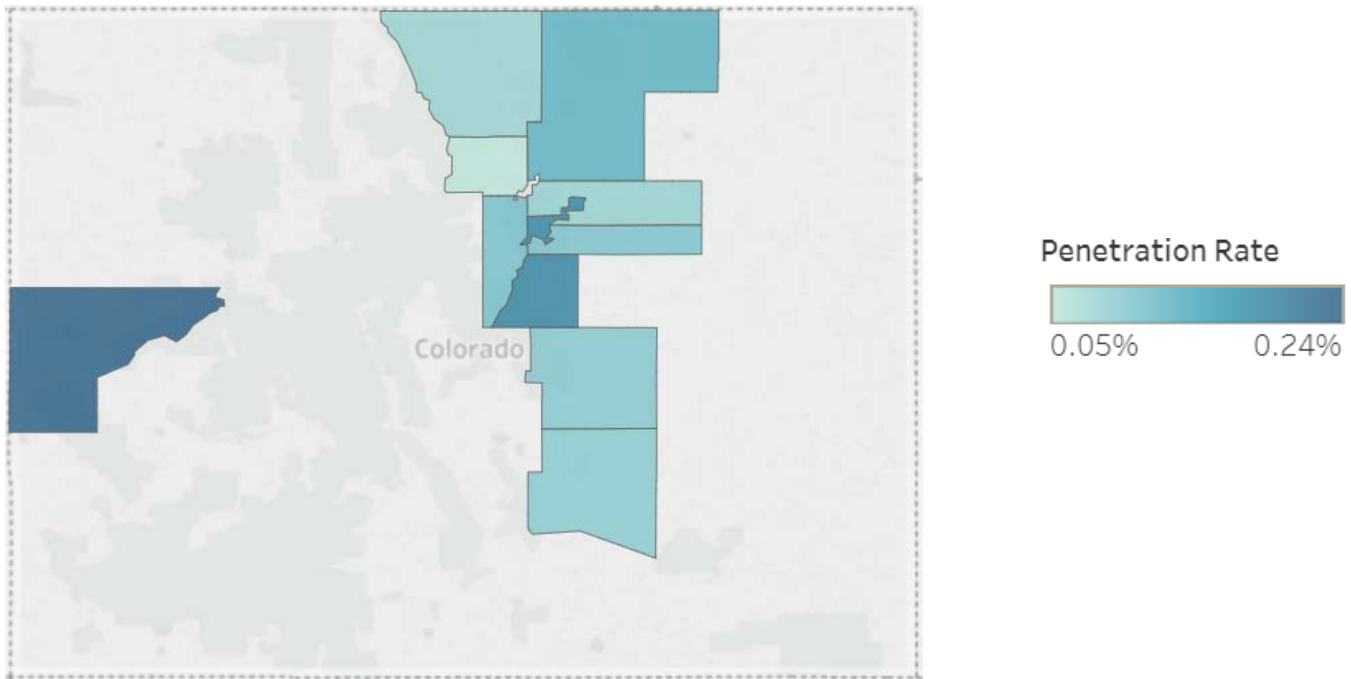


Figure 13. Penetration rates for RCCF services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving RCCF services.

Member-to-Provider Ratio

The member-to-provider ratio indicates the total number of RCCF service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

RCCF Member-to-Provider Ratios			
Region	FY 2017-18 Providers	FY 2017-18 Members	Providers per 1,000 Members
Frontier	67	41,742	1.61
Rural	102	162,003	0.63
Urban	144	1,217,439	0.12
Statewide	144	1,408,747	0.10

Table 12. Member-to-provider ratio for RCCF expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban

counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.⁴⁶

Drive Times

There were no drive times calculated for the RCCF service grouping due to the residential nature of the services.

Stakeholder Feedback

During the March 29, 2019 MPRRAC meeting,⁴⁷ stakeholders provided comments regarding RCCF services and rates, which included:

- The number of youths placed in RCCFs has decreased significantly.
- In the last 10 years, over 23 residential programs closed. Out of 33 RCCF providers listed on the Colorado state vendor list published in July 2017, only 21 are still operating. Reduction of the number of residential treatment facilities is harmful and creates a barrier to receiving necessary treatment.
- Youth placed in out of home care require greater supervision, more treatment services, greater psychiatric oversight, and more medical services.
- Residential treatment providers reported that 2018 funding covered less than 78% of audited costs.
- Colorado is experiencing record low unemployment rates which makes it more difficult to be competitive in hiring, especially considering the 115% increase in Colorado’s minimum wage from 2000 to 2019.⁴⁸

Additional Research

The Department plans to conduct additional research of factors influencing access to RCCF services, regional differences, and stakeholder feedback. The Department will also consider the utilization of other services across the continuum of care, as well as state initiatives to decrease residential-based treatments and increase in-home and community-based services.

Conclusion

Analyses are inconclusive to determine if RCCF payments at 68.56% of the benchmark were sufficient to allow for member access and provider retention.

⁴⁶ Currently, the Department does not use member-to-provider ratio standards specific to RCCF services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist to determine whether the supply of providers is improving over time.

⁴⁷ March MPRRAC meeting materials can be accessed on the [Department website](#).

⁴⁸ This information was provided by the [Colorado Association of Family and Children’s Agencies](#).

Psychiatric Residential Treatment Facilities

Service Description

A Psychiatric Residential Treatment Facility (PRTF) is an inpatient psychiatric facility for Colorado Medicaid members under the age of 21 who need intensive psychiatric care in a residential setting.

The PRTF service grouping is comprised of 1 revenue code. The PRTF revenue code is a per-diem facility payment that includes all physical and behavioral health care, as well as 24-hour maintenance care, including room and board.⁴⁹ PRTF services also include 24-hour nursing care and awake staff onsite.

The PRTF service grouping has a low number of utilizers, which restricts the Department’s ability to show utilization data due to PHI.⁵⁰ The Department conducted a rate comparison analysis using the Colorado Medicaid per diem PRTF rate compared to other states’ rates that reflect the same services.

PRTF Statistics	
Total Adjusted Expenditures FY 2017-18	\$96,372
Total Rendering Providers FY 2017-18	1
FY 2018 Over FY 2017 Change in Rendering Providers	0.00%

Table 13. PRTF total expenditure and rendering provider data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for PRTFs are 114.36% of the benchmark.⁵¹ A summary of the estimated total expenditures resulting from using comparable sources is presented below.

PRTF Rate Comparison Analysis					
State	Rate	Revenue Code	Procedure Code	Unit Value	Service
Colorado	\$402.21	911	--	Per Diem	Psychiatric/Psychological Rehabilitation
Montana	\$327.48	124	--	Per Diem	In-State PRTF
Nebraska	\$337.20	--	T2033	Per Diem	PRTF – Specialty
Nebraska	\$316.93	--	T2048	Per Diem	PRTF – Community Based Non-Specialty
Mississippi ⁵²	\$425.26	--	--	Per Diem	PRTF Treatment Facility Rates

Table 14. Comparison of Colorado Medicaid PRTF service payments to those of other states’ Medicaid rates (based on the most recent available public information).

⁴⁹ The county placing the member into the PRTF pays 20% of the per diem rate, which covers the cost of room and board. The county’s payment is paid at the beginning of the year with forecasted data estimating the utilization of PRTF services.
⁵⁰ The Department blinds PHI data if services are utilized by less than 31 individuals to protect Colorado Medicaid members’ identities.
⁵¹ The benchmark for the PRTF service grouping was calculated using the average rate of all other states’ rates.
⁵² The Mississippi rate is an average of all statewide facility rates.

PRTF Rate Benchmark Comparison		
Colorado Per Diem Rate	Comparison Repriced	Rate Benchmark Comparison
\$402.21	\$351.72	114.36%

Table 15. Comparison of Colorado Medicaid PRTF service payments to those of other payers, expressed as a percentage (FY 2018).

Access to Care Analysis

The Department cannot perform an access to care analysis for PRTFs due to PHI.

Stakeholder Feedback

During the MPRRAC meeting on March 29, 2019, the sole rendering PRTF provider shared that the PRTF per diem rate barely covers operational costs for the facility.⁵³

Additional Research

The Department identified several factors that could be contributing to low utilization of PRTF services. These factors include, but are not limited to:

- licensing rules that require RCCF facilities be on a different site than PRTFs;
- the prospective payment model requiring counties to pay 20% of the per diem rate to cover room and board at the beginning of each year;⁵⁴
- RCCF services have evolved to meet the need for higher levels of care that were originally only provided at PRTFs; and
- PRTF per diem rate has only received across the board (ATB) increases since it was actuarially set.⁵⁵

The Department plans to conduct additional research of factors influencing access to PRTF services, as well as payment models, county practices, and stakeholder feedback. The Department will also consider the utilization of other services across the continuum of care.

Conclusions

Analyses were inconclusive to determine if PRTF payments at 114.36% of the benchmark were sufficient to allow for member access and provider retention.

⁵³ For more information on comments provided during the March MPRRAC meeting, please see the [Department website](#).

⁵⁴ Because payments are prospective, counties may pay more funds than are realized throughout the year, yet counties do not receive reimbursement if funding is unused.

⁵⁵ The PRTF per diem rate was actuarially set in FY 2014-15 at \$390.77; across the board increases occurred on a yearly basis, resulting in the current rate at \$402.21, set in FY 2018-19. For more information, please see the [PRTF Fee Schedule](#).

Special Connections Program Services

Service Description

Special Connections is a program for pregnant women enrolled in Colorado Medicaid who have alcohol and/or drug abuse or dependence issues. Special Connections helps women have healthier pregnancies and healthier babies by providing case management, individual and group counseling, and health education during pregnancy and up to one year after delivery.⁵⁶ Special Connections services are in addition to the prenatal care a woman receives from her doctor or nurse-midwife.

Services can be outpatient or residential depending on a woman’s level of risk. Services include:

- Case management
- Group health education with other pregnant women
- Group substance abuse counseling with other pregnant women
- In-depth risk screening
- Individual substance abuse counseling
- Referral to appropriate aftercare and ongoing support
- Urine screening and monitoring

The Department shares Special Connections program administration with the Office of Behavioral Health (OBH) within the Colorado Department of Human Services (CDHS). The Department is responsible for payment of medical services, maintaining federal authority to receive Federal Financial Participation, resolving claims and other system payment issues, and program implementation via RAEs, which have a robust behavioral health benefit.⁵⁷

The Department does not currently have claims data from the Special Connections Program.⁵⁸ The lack of claims data impacted the utilizer and provider statistics, rate comparison analysis, and access to care analysis.

According to OBH data, 277 women were admitted to the program January 2017-November 2018.⁵⁹

Special Connections Utilization History					
Fiscal Year	Total Women Served	Cost per Member Overall	Cost per Member – Residential Services	Average Cost per Member – Outpatient Services	Percent of Average Cost per Member to Residential Cost
FY 2014-15	212	\$4,507.15	\$8,745.77	\$185.56	94.28%
FY 2015-16	159	\$4,798.83	\$8,097.26	\$160.33	96.57%

Table 16. Special Connections utilization history and average costs per member.

There are currently ten providers servicing the Special Connections Program, two of which were recruited in FY 2017-18, which is a 20% year-over-year increase in providers from FY 2016-2017 to FY 2017-2018.⁶⁰ Each provider

⁵⁶ Women can only receive services up to one year postpartum if they were enrolled prenatally.

⁵⁷ OBH is responsible for payment of room and board. Please see the Slide 9 in the [March MPRRAC Presentation](#) for more information.

⁵⁸ The implementation of a new claims payment system and the associated rule change to include a new, isolated provider type interfered with claims data submission. The Department is working to retroactively input utilization data to use in future analyses.

⁵⁹ Data was provided by OBH; the Department does not have access to utilization data for FY 2016-17 at this time.

⁶⁰ For a list of current Special Connections providers, please see the list posted on the [Department website](#).

is allowed 16 beds for members receiving residential services; there are currently 56 beds available across the state.⁶¹

Special Connections service utilization can be broken down into the following three groups:

- Intensive Residential Services – serves approximately 71% of Special Connections utilizers.
- Outpatient Services – serves 18% of Special Connections utilizers.
- Therapeutic Community – serves approximately 11% of Special Connections utilizers.

The Special Connections service grouping is comprised of five procedure codes, including H0004, H1000, H1002, H1003, and H2036, all of which have the HD modifier.⁶²

Rate Comparison Analysis

Colorado Medicaid reimburses for five procedure codes.⁶³ A summary of the reimbursement rate and estimated benchmarks for each code resulting from using comparable sources is presented below.

Special Connections Rate Comparison							
Code	Colorado Modifiers	Colorado Rate	Number of Comparison Rates Identified	Lowest Other State Rate	Highest Other State Rate	Other State Average	Colorado as a Percent of Other State Average
H0004	HD	\$14.04	30	\$3.19	\$128.96	\$28.31	49.59%
H0004 ⁶⁴	HD, HQ	\$7.50	30	\$3.19	\$128.96	\$28.31	26.51%
H1000	HD	\$105.39	5	\$8.41	\$40.00	\$16.71	630.72%
H1002	HD	\$8.79	1	\$48.79	\$48.79	\$48.79	18.01%
H1003	HD	\$3.62	2	\$35.00	\$38.92	\$36.96	9.78%
H2036	HD	\$192.10	6	\$117.11	\$224.87	\$167.72	114.54%

Table 17. Colorado Medicaid Special Connections rate comparison to other states' Medicaid rates.

Special Connections individual rate ratios ranged from 9.78%-630.72% of the other states' Medicaid rates averages.

Access to Care Analysis

The Department cannot perform an access to care analysis for Special Connections program services due to lack of available claims data for analysis.

⁶¹ Beds are reserved for women based on level of risk; beds are also reserved for any dependent children that accompany the mother during treatment.

⁶² H0004 has two rates, one for individual therapy (HD modifier), and one for group therapy (HD and HQ modifiers).

⁶³ These codes are also used for SUD services, so it is important to note that when used for Special Connections, they are modified with the HD modifier for Colorado Medicaid. Please see Appendix C for a description of each code.

⁶⁴ Other states did not tend to use the same modifiers as Colorado, so the Department applied the same comparison rate for H0004-HD and H0004-HQ.

Stakeholder Feedback

The Department received feedback from stakeholders regarding the Special Connections program, both through the rate review process and through other feedback channels.⁶⁵

Stakeholder feedback the Department received prior to the MPRRAC meeting on March 29, 2019 included:

- There are access issues due to the restrictions on program eligibility⁶⁶ and difficulties providing residential services for pregnant women with dependent children.⁶⁷
- The current Special Connections service rates are too low for program sustainability; the program requires providers with specialized qualifications and federal regulations limit institutes of mental disease to 16 beds.
- The reimbursement rate for outpatient SUD services negotiated through the RAEs is higher than the rate for similar outpatient services through the Special Connections program.

Stakeholder comment during the March 29, 2019 MPRRAC meeting included:

- The 56 beds available for Special Connections members are not solely allocated for women receiving Special Connections services, but also for pregnant women and parents who are not enrolled in the Medicaid program. As a result, the payer and a woman's situation (e.g., pregnant, with children) may be a consideration for providers accepting patients.
- There is currently an eight to twelve week waiting period for women who are placed on the wait list for Special Connections services. This equates to an entire trimester for pregnant women who are seeking substance abuse treatment. The long wait for treatment creates additional risks to both the woman and her child.
- The state is paying for the consequences of not treating these women and their families through the child welfare system and the criminal justice system, as well as other healthcare costs that arise from not receiving the care they need prenatally.
- The cost of treatment can range from \$392 to \$417 per day, but the current rate for Special Connections services is set at \$192 per day. This low rate is prohibiting providers from entering the program, delivering the services, continuing to deliver the services, and ultimately pushes providers to serve other populations that reimburse at higher rates for the same or similar services.
- The operational challenges for these programs and the treatments provided by these programs tend to be complex in nature. Accommodating the family unit within a treatment setting is one example and can be associated with longer clinical hours, higher levels of staff specialty, and higher costs for treatment in general.
- Childcare costs are not included in Colorado Medicaid Special Connections rates.

Additional Research

OBH provided the Department with Special Connections Program utilization data they collected since FY 2014-15, as well as qualitative survey data regarding other states' Medicaid rates for similar services to the same population. This data helped the Department analyze the Special Connections rate comparison data and informed access to care considerations for the Special Connections program.

⁶⁵ Department subject matter experts (SMEs) shared additional feedback they received from various stakeholders prior to the March 29, 2019 MPRRAC meeting.

⁶⁶ Mothers must enroll prenatally to access post-partum services offered up to a year after giving birth.

⁶⁷ Mothers who have other dependent children require more resources in residential settings.



The Department, in partnership with OBH, plans to conduct additional research of factors influencing access to Special Connections services, including, but not limited to rates, program admission requirements, and waitlists. The Department will also evaluate stakeholder feedback and additional claims data as it becomes available. The Department will also consider the utilization of other services across the continuum of care.

Conclusion

Analyses are inconclusive to determine if Special Connections payments ranging from 9.78%-630.72% were sufficient to allow for member access and provider retention.

Dialysis and End-Stage Renal Disease Services

Service Description

The Dialysis and End-Stage Renal Disease (ESRD) service grouping is comprised of six facility revenue codes, including 821, 829, 841, 851, 881, 829; and five professional procedure codes, including 90937, 90989, 90993, 90963, 90966.

Dialysis and ESRD Statistics	
Total Adjusted Expenditures FY 2017-18 – Facility	\$8,688,691
Total Adjusted Expenditures FY 2017-18 – Professional	\$58,931
Total Members Utilizing Services FY 2017-18	572
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	13.72%
Total Rendering Providers FY 2017-18 ⁶⁸	88
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	1.15%

Table 18. Dialysis and ESRD services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for dialysis and ESRD facility services are 83.26% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below for dialysis and ESRD facility rates.⁶⁹

Dialysis and ESRD Rate Benchmark Comparison – Facility Rates			
Wage Index Region	Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
Boulder, CO	\$397,734	\$524,341,423	73.46%
Colorado Springs, CO	\$733,096	\$856,550	85.59%
Denver, Aurora, Lakewood	\$5,919,790	\$7,071,629	83.71%
Fort Collins, CO	\$225,671	\$294,733	76.57%
Grand Junction, CO	\$68,938	\$93,750	73.53%
Greeley, CO	\$443,701	\$565,291	78.49%
Pueblo, CO	\$374,839	\$416,414	90.02%
Rural Colorado	\$609,871	\$697,243	87.47%
All Colorado	\$8,773,641	\$10,537,036	83.26%

Table 19. Comparison of Colorado Medicaid dialysis and ESRD facility service payments, broken down by Wage Index Region, to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be \$1,763,395 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. All the codes in the dialysis and ESRD facility service grouping

⁶⁸ Dialysis facilities provider counts were calculated using billing provider IDs.

⁶⁹ For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.

were compared to adjusted Medicare rates. Dialysis and ESRD regional facility rate ratios ranged from 73.46%-90.02%.

On average, Colorado Medicaid payments for dialysis and ESRD professional services are 77.01% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below for dialysis and ESRD professional rates.

Dialysis and ESRD Rate Benchmark Comparison – Professional Rates		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$59,507	\$77,269	77.01%

Table 20. Comparison of Colorado Medicaid dialysis and ESRD professional service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be \$17,762 in total funds if Colorado reimbursed at 100% of the combined benchmark in FY 2017-18. Of the five procedure codes analyzed in the dialysis and ESRD professional service grouping, three procedure code rates were compared to Medicare rates, one procedure code rate was compared to an average of seven other states’ Medicaid rates,⁷⁰ while one procedure code had no comparable rate. Individual dialysis and ESRD professional service rate ratios ranged from 68.36%-109.35%.⁷¹

⁷⁰ States used in the dialysis and ESRD professional rate comparison analysis were Arizona, Nebraska, Oklahoma, Oregon, Wyoming, California, and Idaho. For more details regarding the dialysis and ESRD rate comparison analysis, please see Appendix B.

⁷¹ The dialysis and ESRD facility and professional payments together come to 83.22% of the benchmark.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

In urban counties, utilizers per provider for dialysis and ESRD services were 3.17 in FY 2015-16 and increased to 3.70 in FY 2016-17 and to 4.16 in FY 2017-18.



Figure 14. Utilizers per provider (panel size) for dialysis and ESRD services between July 2015 and June 2018.

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time. Distinct utilizers increased at a higher rate which led to the increase in the number of utilizers per provider.⁷²

The increases in both active providers and distinct utilizers in the urban counties may indicate improvements in access to care for dialysis services in these areas.

The Department is unable to show utilizers per provider information for rural and frontier counties due to PHI. However, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.⁷³

⁷² For data specific to distinct utilizers and active providers, please see Appendix C.

⁷³ For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of dialysis services reside throughout the state. In FY 2017-18, Weld County had the lowest number of utilizers at 42 and Denver County had the highest number of utilizers at 123.

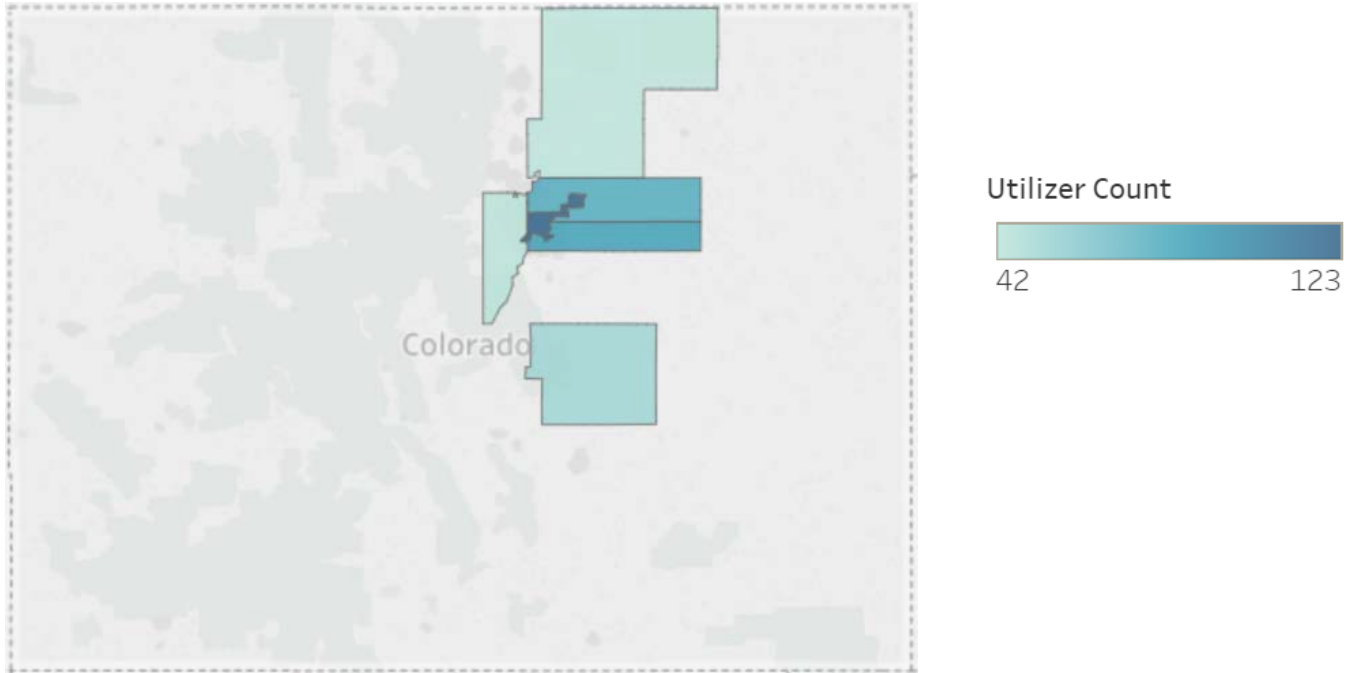


Figure 15. Utilizer density for dialysis and ESRD services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for dialysis services, or a low number of Colorado Medicaid members with ESRD and/or acute kidney failure;
- accessing services in other settings not included in this analysis.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received dialysis or ESRD services. Penetration rates in FY 2017-18 ranged from 0.02% in El Paso County to 0.07% in Denver County.

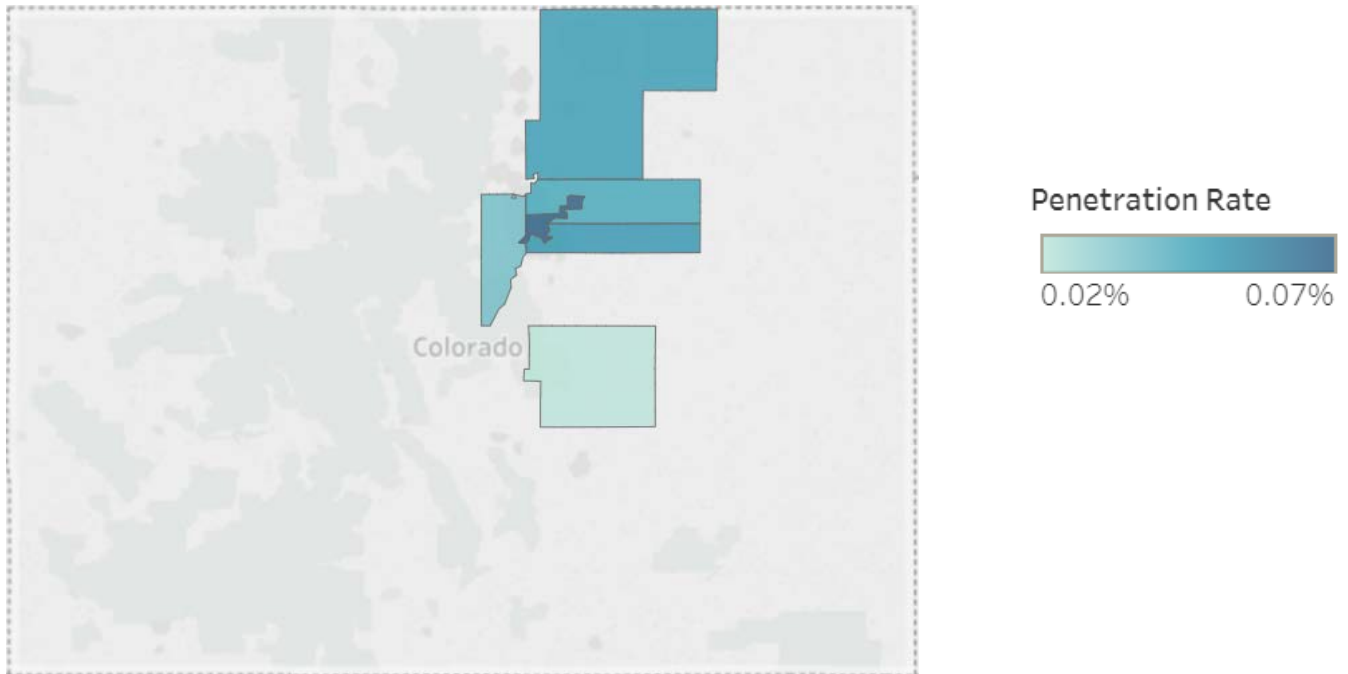


Figure 16. Penetration rates for dialysis and ESRD services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving dialysis services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of dialysis and ESRD service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

Dialysis and ESRD Member-to-Provider Ratios			
Region	FY 2017-18 Providers	FY 2017-18 Members	Providers per 1,000 Members
Frontier	10	41,742	0.24
Rural	23	162,003	0.14
Urban	80	1,217,439	0.07
Statewide	88	1,408,747	0.06

Table 21. Member-to-provider ratio for dialysis and ESRD expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.⁷⁴

⁷⁴ Currently, the Department does not use member-to-provider ratio standards specific to dialysis and ESRD services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of dialysis and ESRD services utilizers that live within certain drive time bands from where dialysis and ESRD services have been provided.

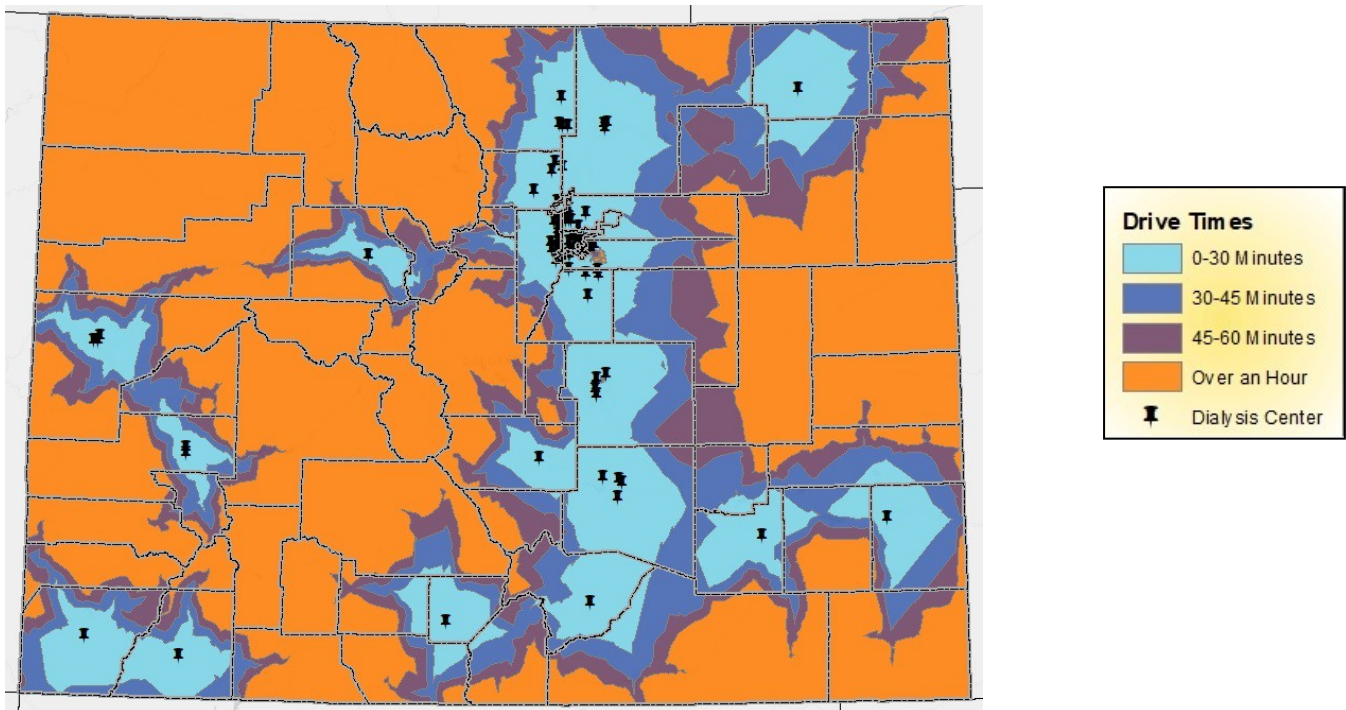


Figure 17. ArcGIS map of drive times for utilizers of dialysis and ESRD services in FY 2017-18.

Overall, 89% of the total utilizers of dialysis and ESRD services in FY 2017-18 needed to travel approximately 30 minutes or less to reach a location where one of these services had been provided. Additionally, 4% of the total utilizers needed to travel approximately 30-45 minutes; 4% of the total utilizers needed to travel approximately 45-60 minutes. Finally, 3% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered.

Stakeholder Feedback

The Department did not receive stakeholder feedback on dialysis and ESRD services.

Additional Research

The Department plans to conduct additional research related to noted regional differences.

Conclusion

Analyses suggest that dialysis and ESRD payments at 83.22% of the benchmark were sufficient to allow for member access and provider retention.⁷⁵

⁷⁵ The dialysis and ESRD facility payments were at 83.26% of the benchmark and dialysis and ESRD professional payments were at 77.01% of the benchmark; facility and professional payments together come to 83.22% of the benchmark.

Durable Medical Equipment

Service Description

The durable medical equipment (DME) service grouping is comprised of 729 procedure codes.⁷⁶

DME Statistics	
Total Adjusted Expenditures FY 2017-18	\$56,415,187
Total Members Utilizing Services FY 2017-18	42,579
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	0.75%
Total Rendering Providers FY 2017-18	217
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	(8.82%)

Table 22. DME services expenditure and utilization data.

The Consolidated Appropriations Act of 2016 requires Colorado Medicaid to reimburse certain DME codes at no greater than 100% of the Medicare rate if those codes were covered by both Medicare and Medicaid in the previous fiscal year.^{77,78} In calendar year (CY) 2018, 244 DME codes were subject to this Upper Payment Limit (UPL), 137 of which are included in the Year Four rate review.⁷⁹

Because certain DME rates under review are subject to UPL limits, while others are not, the Department used three different comparison sources to analyze DME rates:⁸⁰

- UPL codes were compared to Medicare rates.⁸¹
- Non-UPL codes with a Medicare comparator were compared to Medicare rates.
- Non-UPL codes without a Medicare comparator were compared to Medicaid rates in six other states.⁸²

The following Rate Comparison and Access Analysis sections contain separate findings for UPL and non-UPL DME.

⁷⁶ Only DME codes that start with the letters A, E, and K are under review in Year Four of the rate review process; orthotics, prosthetics, and disposable supplies will be reviewed in Year Five of the rate review process. Not all codes had a comparator rate, and thus were not included in this analysis.

⁷⁷ DME codes that start with the letters A, E, and K are subject to this limit; orthotics, prosthetics, and disposable supply codes are not.

⁷⁸ For more information about the Upper Payment Limit (UPL) implementation for DME rates, please refer to [this provider communication](#) on the Department's website.

⁷⁹ The original effective date was January 2019; however, CMS passed the 21st Century Cures Act, changing the effective date to January 2018.

⁸⁰ For more information regarding the methodology used to conduct the DME rate comparison analysis, see Appendix B.

⁸¹ For a list of DME UPL codes, please see the [DME UPL fee schedule](#) on the Department website.

⁸² States used in the DME rate comparison analysis were Arizona, California, Nebraska, Oklahoma, Oregon, and Wyoming.

Rate Comparison Analysis

DME Subject to UPL

Colorado Medicaid payments for DME subject to the UPL are 100% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DME Rate Benchmark Comparison – UPL		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$39,450,727	\$39,450,727	100.00% ⁸³

Table 23. Comparison of Colorado Medicaid DME payments (subject to UPL) to those of other payers, expressed as a percentage (FY 2017-18).

Of the 458 procedure codes analyzed in this service grouping, 137 procedure code rates were compared to Medicare rates.⁸⁴

DME Not Subject to UPL

On average, Colorado Medicaid payments for DME not subject to the UPL are 104.83% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DME Rate Benchmark Comparison – Non-UPL		
Colorado Repriced	Comparison Repriced	Rate Benchmark Comparison
\$7,585,351	\$7,235,407	104.84% ⁸⁵

Table 24. Comparison of Colorado Medicaid DME payments (not subject to UPL) to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be a savings of \$349,944 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 458 procedure codes analyzed in this service grouping, 182 procedure code rates were compared to Medicare rates, while 139 procedure code rates were compared to an average of six other states' Medicaid rates. Individual DME service rate ratios ranged from 3.9%-1,478%.⁸⁶

⁸³ These codes are subject to the UPL, and thus are set at 100% of Medicare rates.

⁸⁴ All procedure codes had a comparable rate because all DME codes subject to UPL were paid by both Medicaid and Medicare.

⁸⁵ Colorado Medicaid payments for DME not subject to the UPL are 115.50% of Medicare rates and 99.29% of other states' Medicaid rates. Please see Appendix C for more details regarding the rate benchmark comparison for DME not subject to the UPL.

⁸⁶ For details on individual service rate ratios, please see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size)

Statewide, utilizers per provider for DME services averaged 84.23 in FY 2015-16 and increased to 90.84 in FY 2016-17 and increased to 95.16 in FY 2017-18. Additionally:

- In urban counties, utilizers per provider averaged 71.53 in FY 2015-16 and increased to 77.71 in FY 2016-17 then increased to 81.71 in FY 2017-18.
- In rural counties, utilizers per provider averaged 19.11 in FY 2015-16 and increased to 19.57 in FY 2016-17 then increased to 20.16 in FY 2017-18.
- In frontier counties, utilizers per provider averaged 7.48 in FY 2015-16 and increased to 8.27 in FY 2016-17 then increased to 9.10 in FY 2017-18.

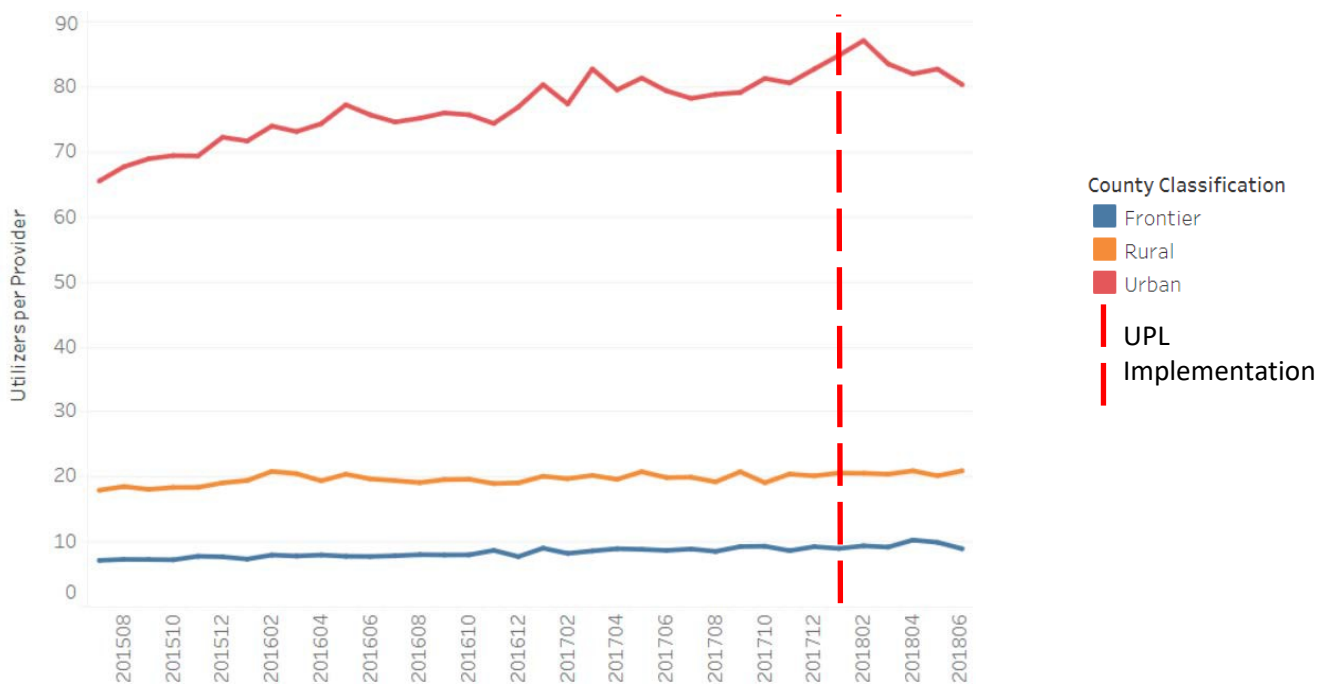


Figure 18. Utilizers per provider (panel size) for DME services between July 2015 and June 2018.

Analysis indicates that there were increases in the number of distinct utilizers and decreases in the number of active providers over this time, which led to the increase in the number of utilizers per provider.⁸⁷

The increase in utilizers per provider in the urban, rural, and frontier counties may indicate changes in access to DME services in these areas.⁸⁸

⁸⁷ For data specific to distinct utilizers and active providers, please see Appendix C.

⁸⁸ For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of DME services reside throughout the state. In FY 2017-18, Phillips County had the lowest number of utilizers at 35 and El Paso had the highest number of utilizers at 6,949.

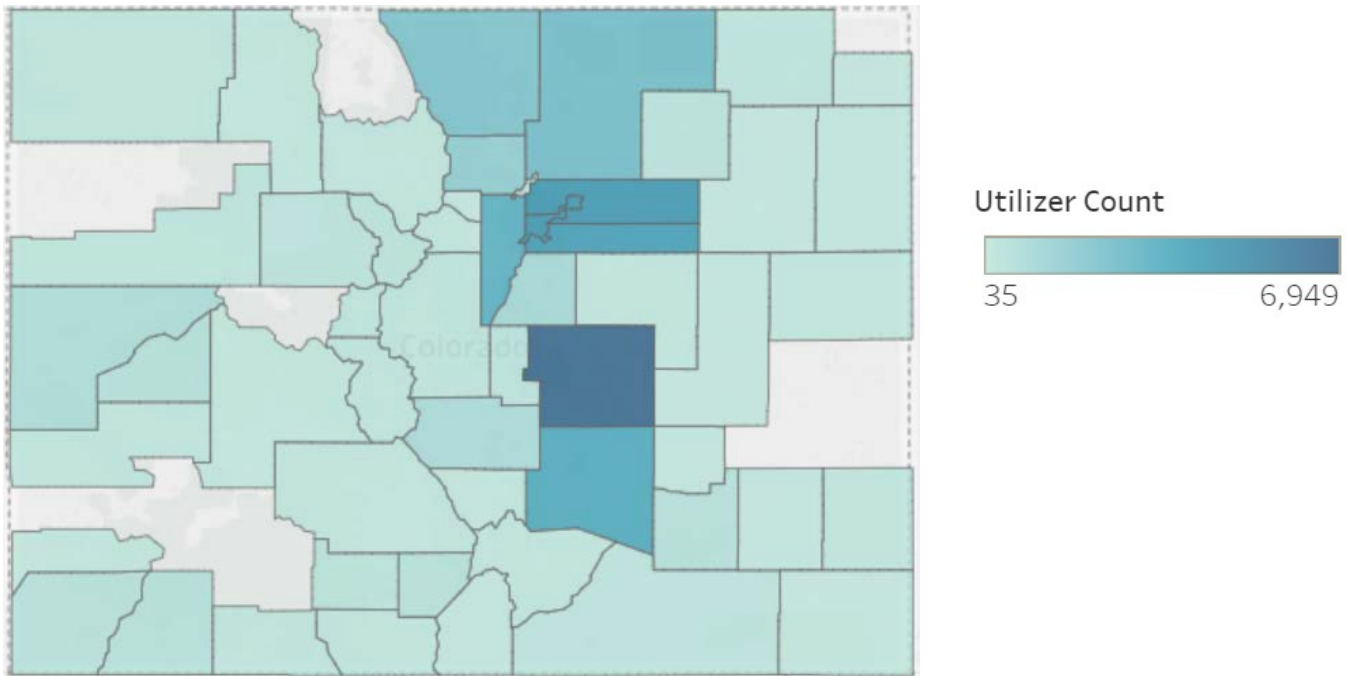


Figure 19. Utilizer density for DME services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for DME services, or a low number of Colorado Medicaid members requiring DME services residing in those counties.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received DME services. Penetration rates in FY 2017-18 ranged from 1.15% in Montrose County to 7.49% in Lake County.

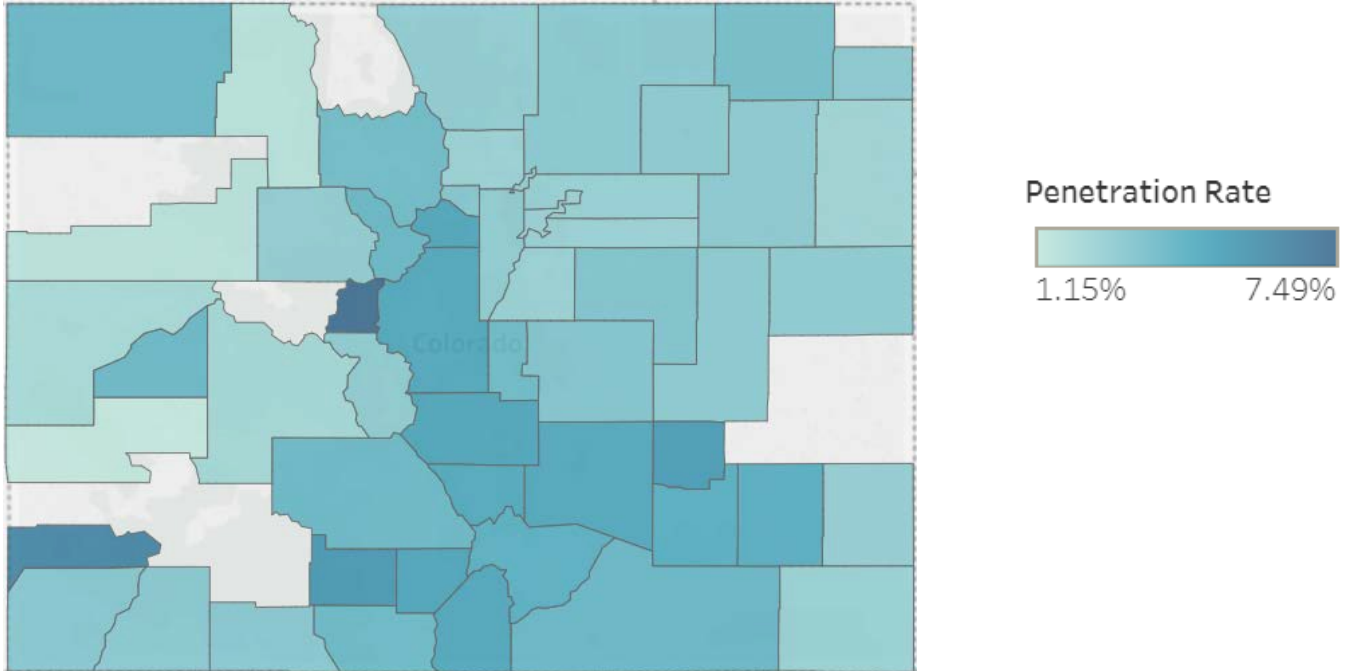


Figure 20. Penetration rates for DME services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving DME services.

Member-to-Provider Ratio

The member-to-provider ratio indicates the total number of DME service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

DME Member-to-Provider Ratio			
Region	FY 2017-18 Providers	FY 2017-18 Members	Providers per 1,000 Members
Frontier	123	41,742	2.95
Rural	158	162,003	0.98
Urban	210	1,217,439	0.17
Statewide	217	1,408,747	0.15

Table 25. Member-to-provider ratio for DME expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.⁸⁹

⁸⁹Currently, the Department does not use member-to-provider ratio standards specific to DME services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.



Drive Times

The drive times metric calculates the percentage of DME services utilizers that live within certain drive time bands from where DME services have been provided.

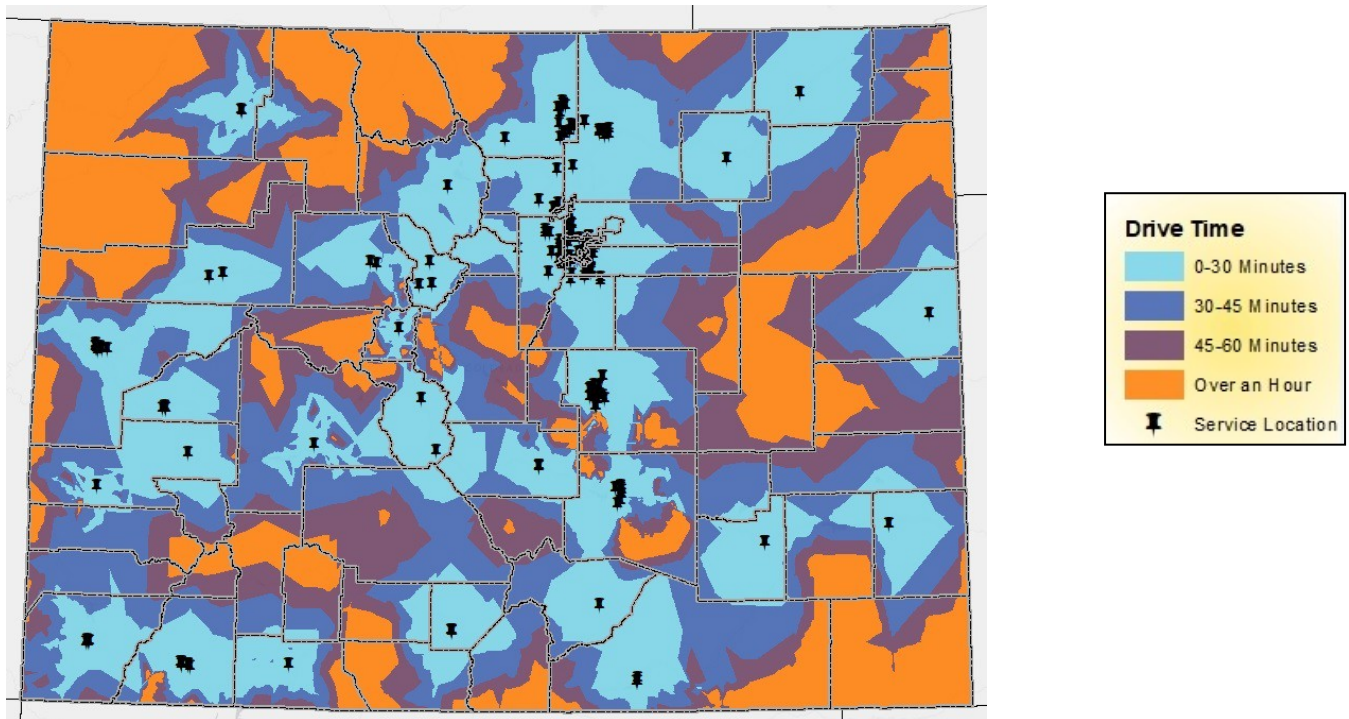


Figure 21. ArcGIS map of drive times for utilizers of DME services in FY 2017-18.

Overall, 94% of the total utilizers of DME services in FY 2017-18 needed to travel approximately 30 minutes or less to reach a location where one of these services had been provided. Additionally, 4% of the total utilizers needed to travel approximately 30-45 minutes; 1% of the total utilizers needed to travel approximately 45-60 minutes. Finally, 1% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered. It should be noted that DME suppliers sometimes travel to members' locations, and the drive times may be indicative of provider travel as well.

Stakeholder Feedback

While the Department did not receive stakeholder feedback during the rate review process, the Department previously received feedback through other outreach methods. Feedback themes include, but are not limited to:

- Colorado Medicaid rates for certain DME supplies, such as wheelchairs (procedure code K0004) and hospital beds (procedure codes E0184 and E0260), are not sufficient for provider retention.
- Colorado Medicaid members are encountering barriers to receiving oxygen, Continuous Positive Airway Pressure (CPAP), and Bilevel Positive Airway Pressure (BiPAP) supplies.⁹⁰

Additional Research

The Department has been aware of the potential impact of, and stakeholder concerns regarding, UPL implementation since before the UPL implementation. Since this time, the Department has:

⁹⁰ For more information regarding Oxygen and CPAP/BiPAP utilization and provider data, please see Appendix C.

- provided state-level feedback to our federal partner, the Centers for Medicare and Medicaid Services (CMS), regarding UPL implementation;
- shared information through existing state legislative processes;
- established a team to monitor recent claims data regarding oxygen-related supplies in response to stakeholder concerns;⁹¹
- closely evaluated data for changes in utilization and provider retention and will continue to do so over the next year;⁹² and
- conducted a second annual survey of DME suppliers, and a 2019 survey of DME providers. Results of the ongoing data analysis, survey results, and stakeholder feedback will be included in the 2019 Access Monitoring Review Plan that will be submitted to CMS October 1, 2019.

Conclusions

Analyses suggest that the DME payments at 104.56% of the benchmark were sufficient to allow for member access. The decrease in active providers, in addition to stakeholder feedback, has indicated that the UPL rates could lead to issues regarding provider retention. Current data suggest that UPL rates are sufficient for provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

⁹¹ Please refer to Appendix C for data regarding oxygen-related supplies.

⁹² This will be done in alignment with the rate review and access to care processes.

Appendices

A. [Glossary](#)

Appendix A provides explanations of common terms used throughout the 2019 Analysis Report.

B. [Rate Comparison Analysis and Access to Care Methodologies and Data](#)

Appendix B includes details of the Year Four services benchmark creation and payment comparison methodology and data, as well as the access to care methodology and data. Appendix B does not include any additional data for Psychiatric Residential Treatment Facilities (PRTFs), due to protected health information, or Special Connections, due to unavailable claims data.

C. [Service Grouping Data Book](#)

Appendix C contains, for each service grouping (except PRTFs), the following information:

- Top 10 procedure or revenue codes by total paid.
- Rate benchmark comparison scatterplots and bar graphs.
- Additional access to care information, including access to care visuals and charts.