Medicaid Provider Rate Review Advisory Committee Meeting

Presented by: Eloiss Hulsbrink

November 15, 2019

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Agenda

Call to Order and Introductions	9:00 AM
Meeting Overview	9:05 AM
Meeting Minutes	9:10 AM
Committee Appointments	9:20 AM
Committee Member Labels and Identification	9:25 AM
Past Years Recommendations Update	9:30 AM
Recommendations for Year Four Services	9:45 AM
Break	*10:00 AM*
Rate Review Year Five Service Definitions and Considerations	10:10 AM
Rate Comparison and Access to Care Metrics	10:50 AM
Data Analysis Considerations	11:15 AM
Next Steps and Announcements	11:45 AM

Ground Rules

- Honor the Agenda
    - Stay solution and scope focused
- Identify yourself before speaking
- Honor and Respect Everyone
    - Mind E-manners
    - Share the air

Protected Health Information (PHI)

- Protected Health Information is individually identifiable information relating to the past, present, or future health status of an individual.
- Information such as diagnoses, treatment information, medical test results, and prescription information are considered PHI under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact/emergency contact information.
- This meeting is recorded and will be made publicly available on the Department website.
- Shared PHI may result in the portions of the meeting recording being deleted and delays posting the meeting recording.

Meeting Minutes

June 28 and September 20, 2019

Committee Appointments

Presented by: Eloiss Hulsbrink

Committee Member Labels and Identification

Presented by: Wilson Pace

Past Years Recommendations Updates

Presented by: Eloiss Hulsbrink

2019 Medicaid Provider Rate Review Recommendation Report

Eloiss Hulsbrink

Final Recommendations

Ambulatory Surgical Centers (ASCs)

- Add clinically appropriate procedure codes to the list of services that can be reimbursed in an ASC setting.
- Eliminate the ASC grouping reimbursement methodology in favor of a more appropriate reimbursement methodology.
- Re-evaluate each service rate relative to the benchmark and evaluate individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.
- Evaluate the potential for creating a Multiple Procedure Discounting reimbursement methodology.
- Conduct additional evaluation of whether costs can be offset by incentivizing migration of appropriate procedures from the hospital to the ASC setting.

FFS Behavioral Health

- Re-evaluate each service rate relative to the benchmark and evaluate individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

Final Recommendations

Special Connections

- Further align with and support Office of Behavioral Health (OBH) efforts to increase data availability, consistency, and validity.
- Further evaluate whether initiating a rate setting project would be beneficial.
- Conduct a provider survey to augment data currently available and to identify areas for impacting program improvement.

Residential Child Care Facilities (RCCFs) / Psychiatric Residential Treatment Facilities (PRTFs)

- Evaluate methods to differentiate payments for RCCFs from other FFS Behavioral Health services.
- Initiate a joint RCCF and PRTF rate setting project using Department best practices to incentivize proper use of each facility type.
- Evaluate the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

Final Recommendations

Dialysis

- Evaluate potential reimbursement method changes for in-home Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) services, which would align more closely with the Medicare payment methodology.
- Evaluate factors that impact utilization of in-home dialysis, including Medicare enrollment and methods to improve access to in-home dialysis options where appropriate.

Durable Medical Equipment (DME)

- Evaluate individual services not subject to the Upper Payment Limit (UPL) that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.
- Continue access to care evaluation of DME services subject to the UPL and work with state and federal partners to identify solutions to impacted services.
- Evaluate the benefit of DME service component reimbursement.

Questions?

Break

Year Five

Schedule, Service Definitions, Utilizer Demographics, Service Summary Statistics, and Top 10 Procedure Code Data

Presented by: Eloiss Hulsbrink

Year Five Schedule

- Introduction to Year Five Services

November 15, 2019

February 2020

- Preliminary Results

- Working Recommendations and Discussion

June 2020

September 2020

- Finalize Recommendations

- Transition to Year One, Cycle Two

November 2020

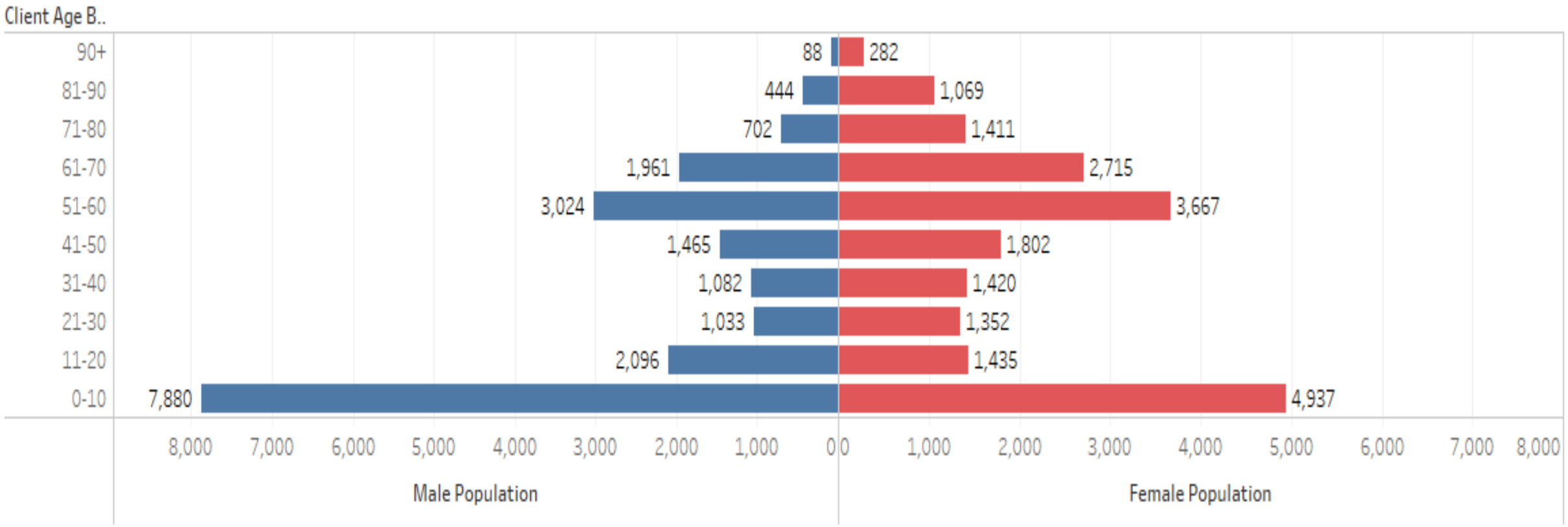
Home Health

- Home Health services consist of skilled nursing, certified nurse aide (CNA) services, physical therapy, occupational therapy, and speech/language pathology services that are provided by a licensed and certified Home Health agency.
- Home Health services are available to Colorado Medicaid members who need intermittent skilled care in their place of residence.
- Home Health services are divided into two service types:
    - Acute Home Health services are provided for the treatment of acute conditions/episodes (such as post-surgical care) for up to 60 days without prior authorization.
    - Long-Term Home Health is available for members who require ongoing Home Health Services beyond the 60-day Acute Home Health period. Long-Term Home Health services require prior authorization.

Home Health

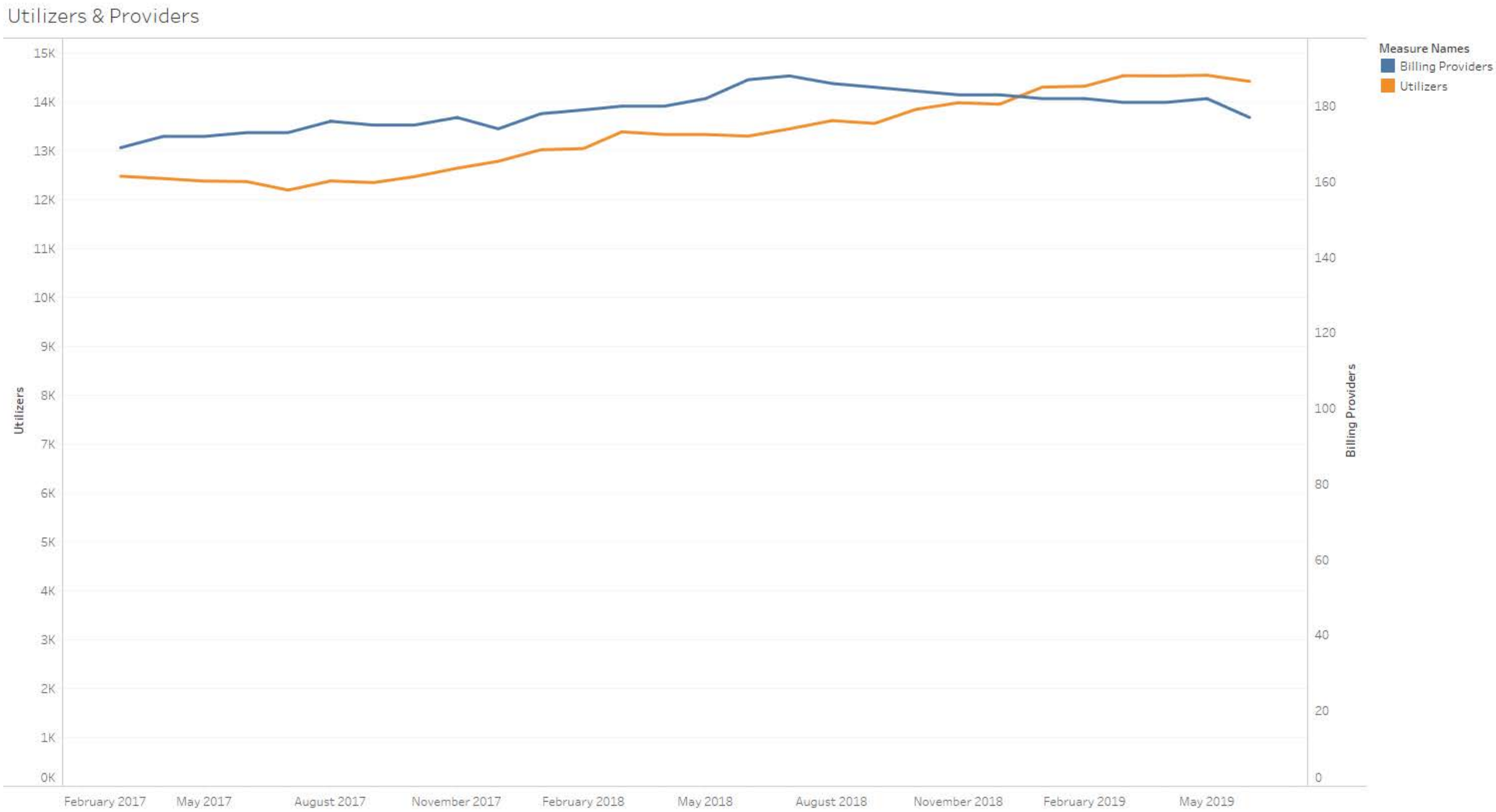
- Members ages 20 and younger:
    - Are assessed for Long-Term Home Health services using the Pediatric Assessment Tool (PAT) and the member's plan of care.
    - May receive Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) in Acute and Long-Term Home Health periods.
- Members ages 21 and older:
    - PT, OT, and SLP shall only be provided in the Acute Home Health episode.

Demographics – Home Health



*DRAFT – All Calculations are Preliminary

Utilizers & Providers Over Time – Home Health



*DRAFT – All Calculations are Preliminary

Service Statistics – Home Health

Home Health Statistics	
Total Paid Dollars FY 2018-19	$391,267,838
Total Members Utilizing Services FY 2018-19	24,859
Total Billing Providers FY 2018-19	197
Total Rendering Providers FY 2018-19	N/A

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – Home Health

Unique Revenue Codes	Top 10 as Percent of Total Services Paid
18	97.35%

Revenue Code	Description	Distinct Utilizers	Allowed Units	Paid Dollars
571	HOME HEALTH – HOME HEALTH AIDE VISIT CHARGE AIDE/H	6,642	4,856,305	$182,768,379
579	HOME HEALTH – HOME HEALTH AIDE OTHER HOME HEALTH A	4,871	6,120,646	$68,962,280
551	SKILLED NURSING VISIT CHARGE SKILLED NURSE/VISIT	6,097	419,066	$45,302,370
441	SPEECH-LANGUAGE PATHOLOGY VISIT CHARGE SPEECH PATH	6,288	192,620	$24,894,517
431	OCCUPATIONAL THERAPY VISIT CHARGE OCCUP THERP/VISIT	4,103	122,295	$14,651,948
550	SKILLED NURSING GENERAL CLASSIFICATION SKILLED NURSE	7,322	107,126	$11,639,783
590	HOME HEALTH – UNITS OF SERVICE GENERAL CLASSIFICATION	805	143,500	$10,650,714
421	PHYSICAL THERAPY VISIT CHARGE PHYS THERP/VISIT	3,001	87,162	$10,374,598
570	HOME HEALTH – HOME HEALTH AIDE GENERAL CLASSIFICATION	2,329	169,817	$6,316,821
420	PHYSICAL THERAPY GENERAL CLASSIFICATION PHYSICAL T	5,585	47,168	$5,325,664

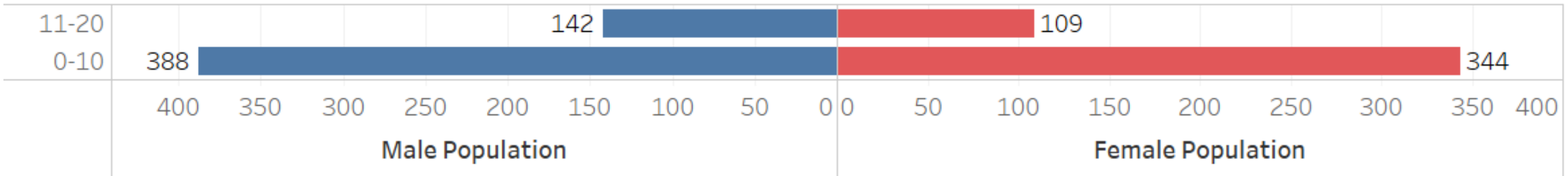
*DRAFT – All Calculations are Preliminary

Questions?

Private Duty Nursing (PDN)

- Continuous one-to-one skilled nursing care provided by a RN or LPN.
- Available to Colorado Medicaid clients who are ***dependent on medical technology*** and need a higher level of care than is available in the Home Health benefit.
    - Per state regulation, PDN services are limited to 16 hours per day.
- Providers that render PDN services must be employed by a licensed and certified Home Health agency.
- PDN services require prior authorization and are assessed using the PDN acuity tool and the client's plan of care.

Demographics - PDN



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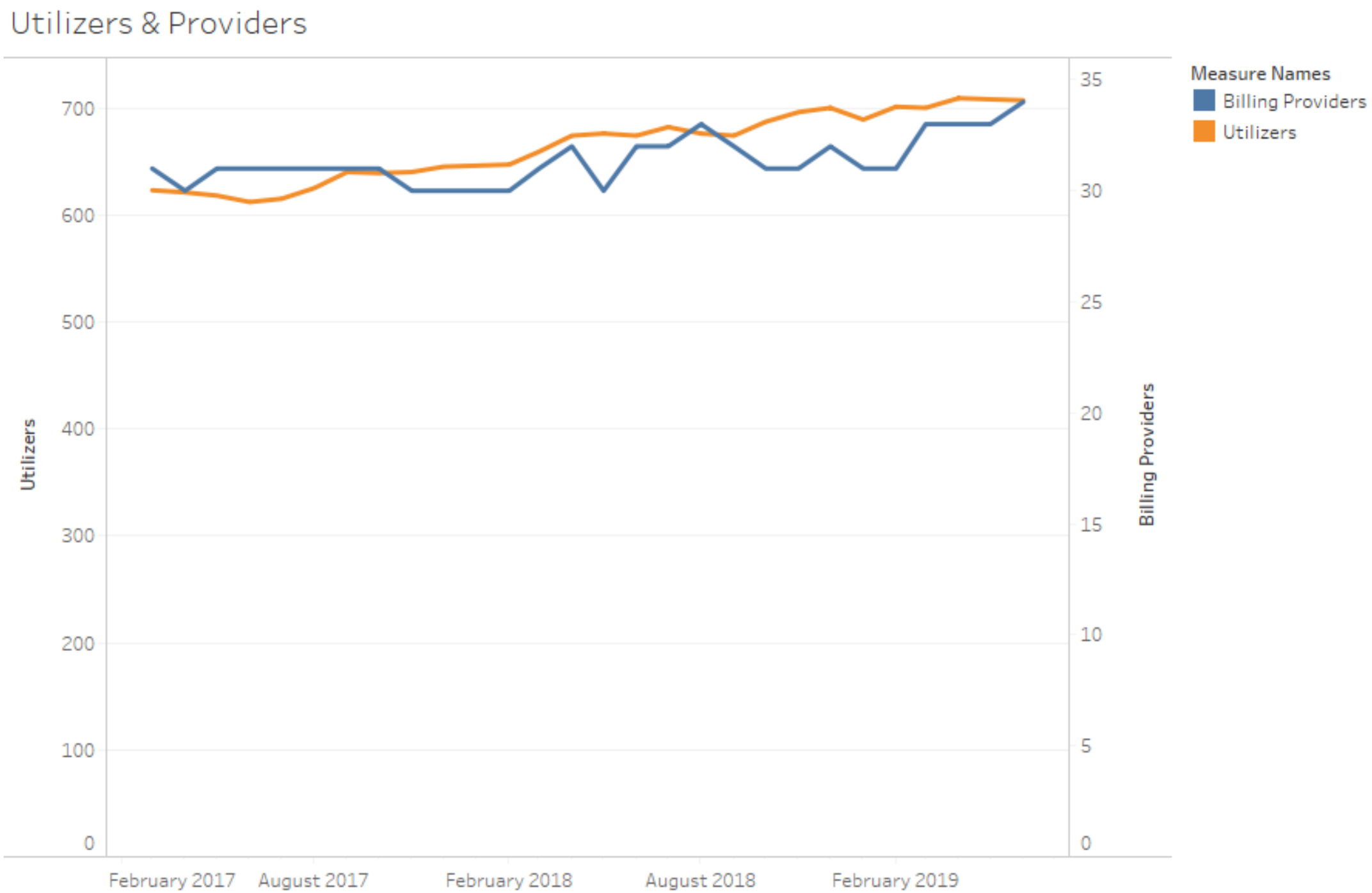
Utilizers & Providers Over Time - PDN



*DRAFT – All Calculations are Preliminary

Service Statistics - PDN

PDN Statistics	
Total Paid Dollars FY 2018-19	$96,364,350
Total Members Utilizing Services FY 2018-19	891
Total Billing Providers FY 2018-19	38
Total Rendering Providers FY 2018-19	N/A

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – PDN

Unique Revenue Codes	Top 5 as Percent of Total Services Paid
5	100.00%

Revenue Code	Description	Distinct Utilizers	Allowed Units	Paid Dollars
552	RN SKILLED NURSE	774	1,450,825	$66,739,927
559	LPN SKILLED NURSE	452	457,904	$15,259,884
582	BLENDED GROUP RATE	113	388,234	$12,217,181
580	RN GROUP VISIT	PHI	PHI	PHI
581	LPN GROUP VISIT	PHI	PHI	PHI

*DRAFT – All Calculations are Preliminary

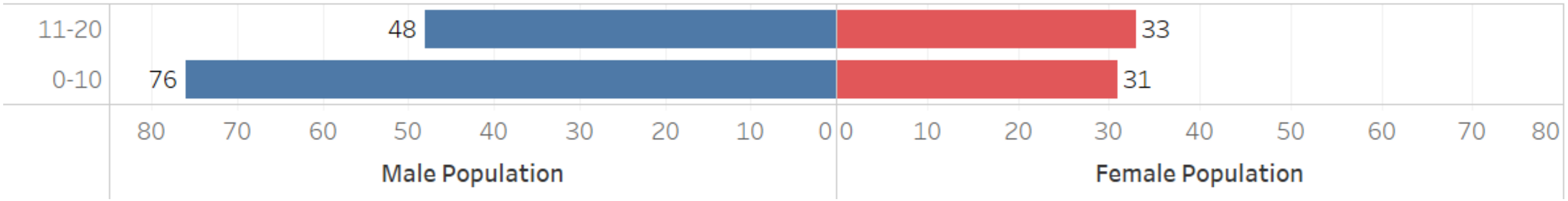
Questions?

Pediatric Personal Care (PPC)

- Available to members 20 years old and younger who require personal care services.
- Personal Care services are medically necessary services that do not require a provider to have a medical certification or a professional license to safely provide services.
- 17 Qualifying Personal Care Tasks:

Ambulation/ Locomotion	Meal Prep	Hygiene – Nail Care	Hygiene – Skin Care	Toileting – Bladder Care	Toileting – Catheter Care
Bathing/ Showering	Feeding	Hygiene – Shaving	Mobility – Positioning	Toileting – Bowel Care	Medication Reminders
Dressing	Hygiene – Hair Care/Grooming	Hygiene – Mouth Care	Mobility – Transfer	Toileting – Bowel Program	

Demographics - PPC



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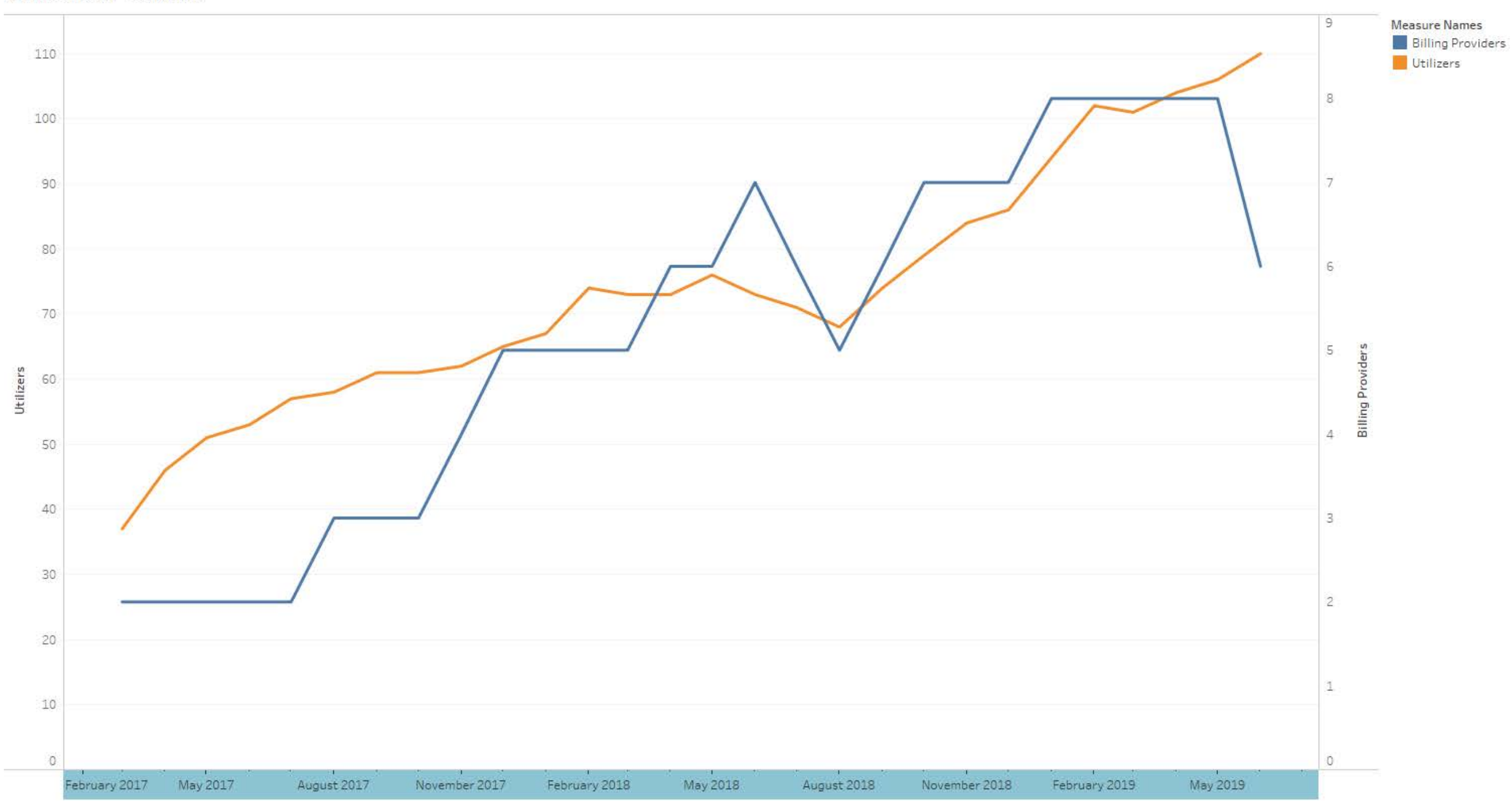
Utilizers & Providers Over Time - PPC



*DRAFT – All Calculations are Preliminary

Service Statistics - PPC

PPC Statistics	
Total Expenditures FY 2018-19	$1,759,223
Total Members Utilizing Services FY 2018-19	137
Total Billing Providers FY 2018-19	8
Total Rendering Providers FY 2018-19	8

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes - PCC

Unique Procedure Codes	Top 1 as Percent of Total Services Paid
1	100.00%

Procedure Code	Description	Distinct Utilizers	Allowed Units	Paid Dollars
T1019	PERSONAL CARE SERVICES PER 15 MINUTES	137	361,836	$1,759,223

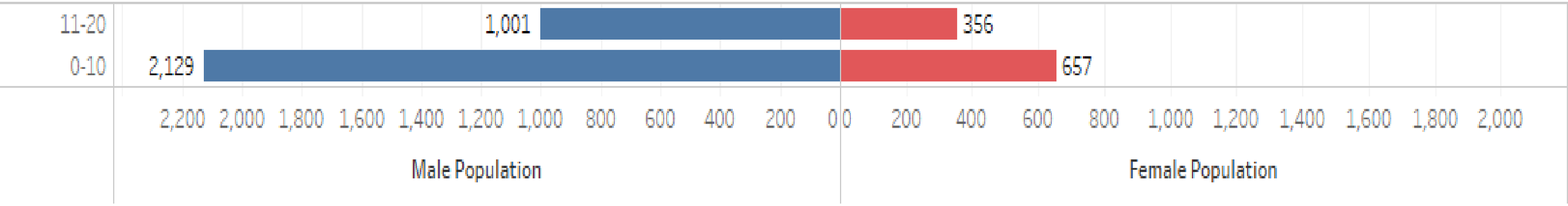
*DRAFT – All Calculations are Preliminary

Questions?

Pediatric Behavioral Therapy (PBT)

- Behavioral therapy services are a treatment that helps change maladaptive behaviors. These services must be found to be medically necessary to be covered.
- Available to members 20 years old and younger who meet the EPSDT medically necessary criteria for behavioral therapy services.
- All PBT services must be pre-approved in a Prior Authorization Request (PAR) process.
- Procedure Codes: 97153, 97154, 97155, 97158, 97151, 97151-TJ

Demographics - PBT



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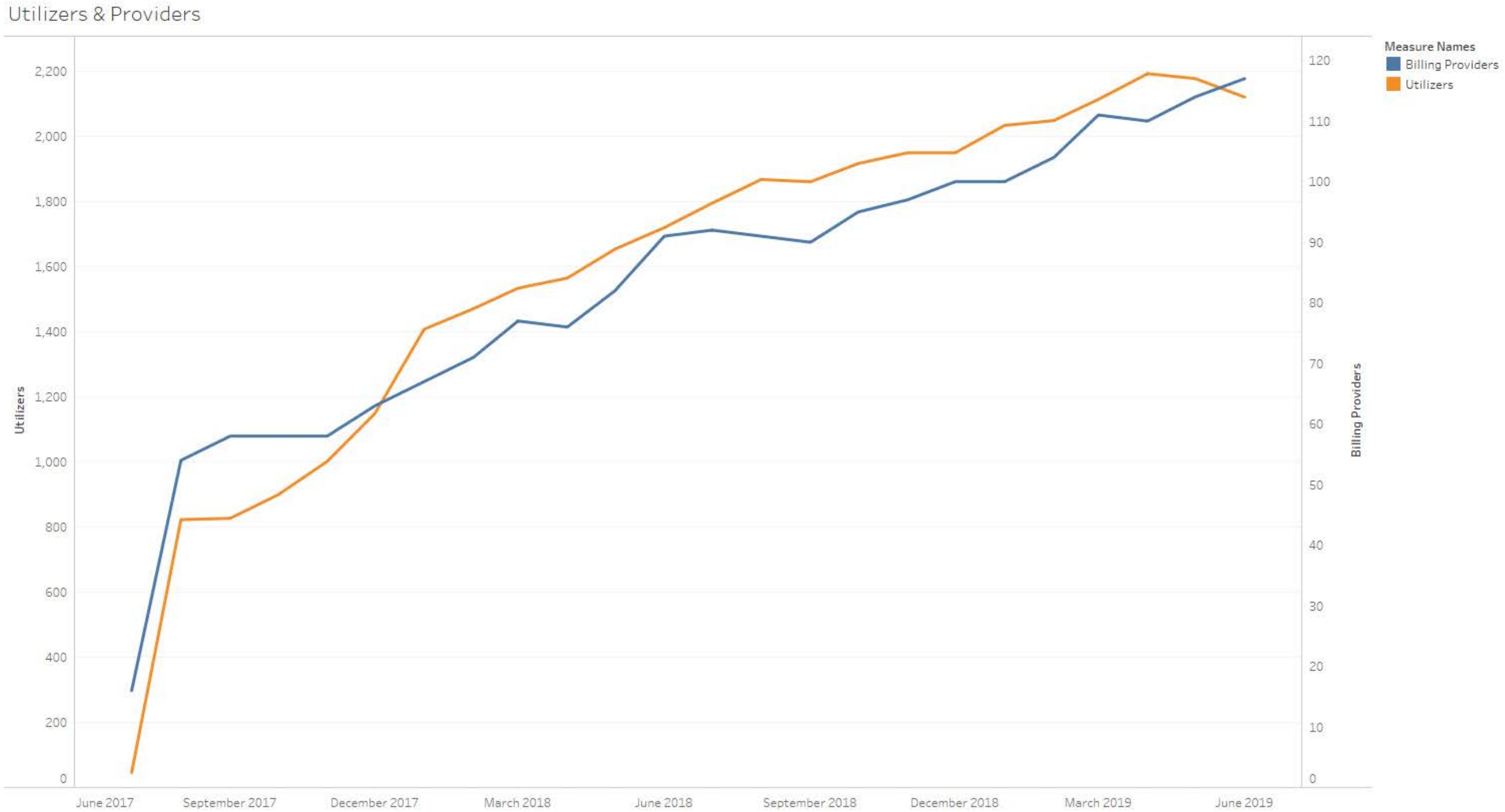
Utilizers & Providers Over Time - PBT



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Service Statistics - PBT

PBT Statistics	
Total Expenditures FY 2018-19	$50,915,640
Total Members Utilizing Services FY 2018-19	3,414
Total Billing Providers FY 2018-19	139
Total Rendering Providers FY 2018-19	431

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – PBT

Unique Procedure Codes	Top 10 as Percent of Total Services Paid
7	99.28%

Procedure Code	Description	Mod 1	Distinct Utilizers	Allowed Units	Paid Dollars
97153	ADAPTIVE BEHAVIOR TX BY TECH		2,340	1,426,169	$18,351,653
H0046	MENTAL HEALTH SERVICE, NOS		2,031	1,332,360	$14,663,215
97155	ADAPTIVE BEHAVIOR TX PHYS/QHP		2,477	407,272	$8,306,516
H0046	MENTAL HEALTH SERVICE, NOS	TJ	2,262	582,970	$7,817,757
97155	ADAPTIVE BEHAVIORA TX PHYS/QHP	TJ	168	23,476	$478,726
97151	BEHAVIORAL ID ASSESSMENT BY PHYS/QHP		1,047	2,116	$337,443
T1024	TEAM EVALUATION AND MANAGEMENT		1,008	1,439	$334,953
97153	ADAPTIVE BEHAVIOR TX BY TECH	HN	PHI	PHI	PHI
97155	ADAPTIVE BEHAVIOR TS PHYS/QHP	HO	32	3,310	$68,926
97153	ADAPTIVE BEHAVIOR TX BY TECH	TJ	PHI	PHI	PHI

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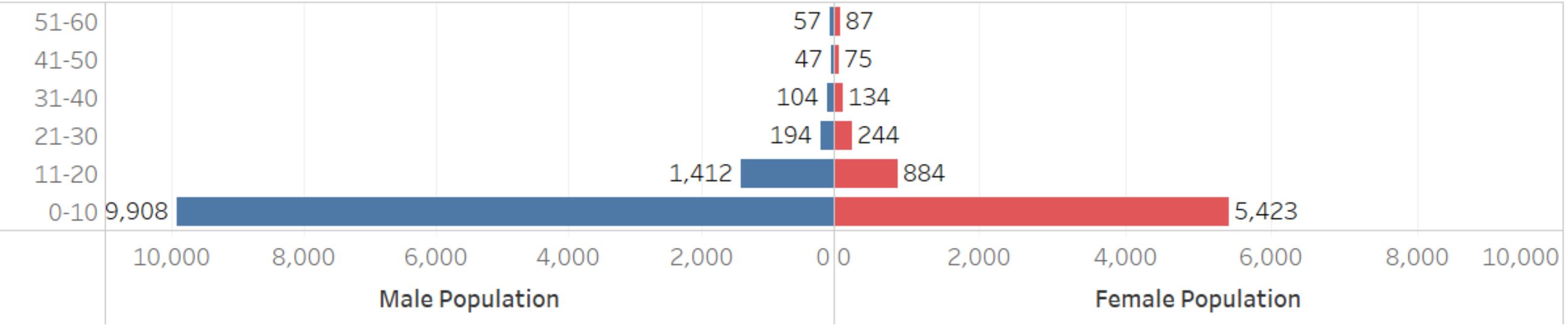
Questions?

Speech Therapy

- Speech Therapy services are outpatient services rendered by a Speech Language Pathologist (SLP), speech therapist, or clinical fellows practicing under the general supervision of a certified SLP.

- Covered services include Assessment, Treatment, Rehabilitative Speech Therapy, and Habilitative Speech Therapy.

Demographics – Speech Therapy



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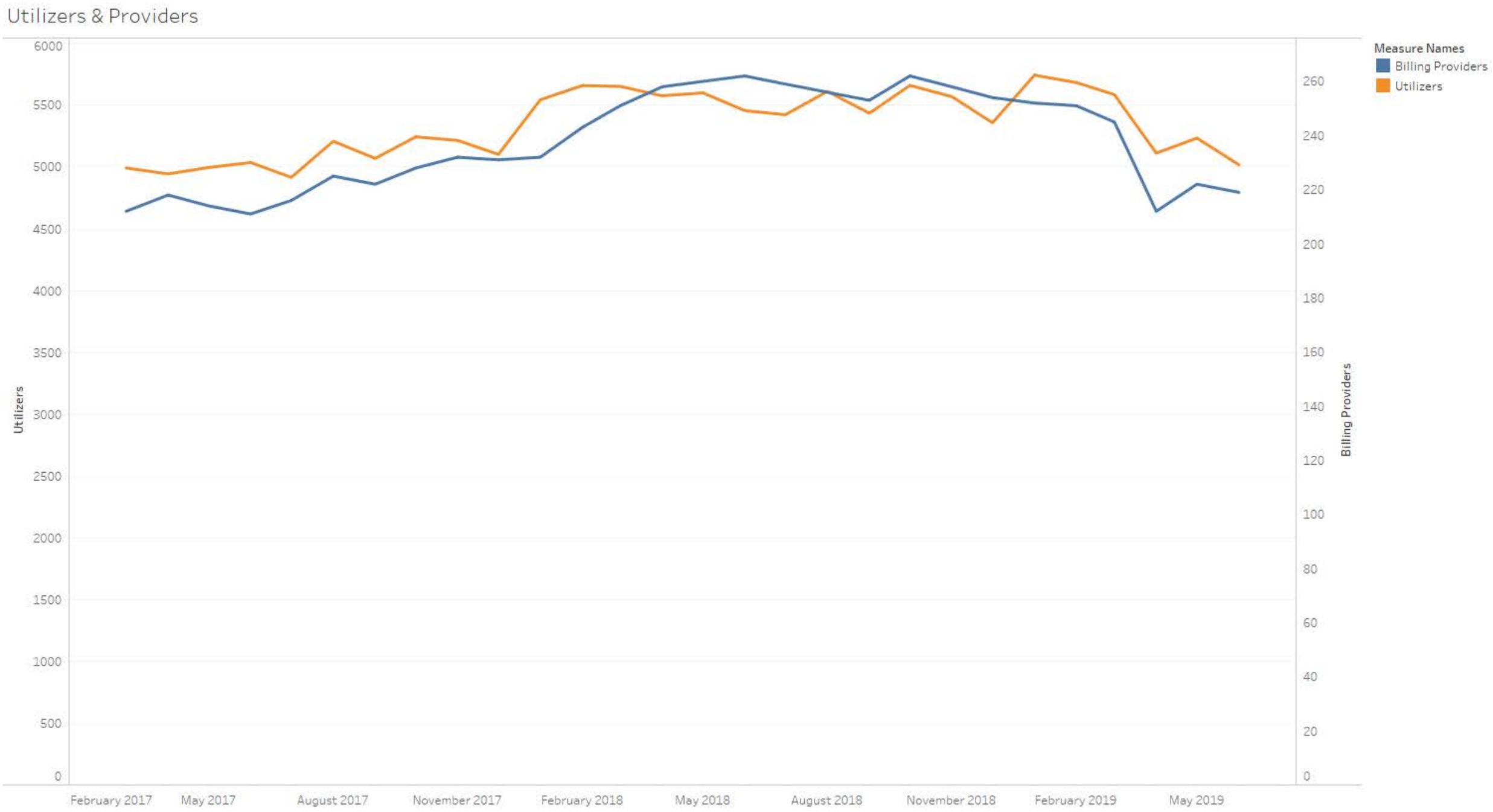
Utilizers & Providers Over Time – Speech Therapy



*DRAFT – All Calculations are Preliminary

Service Statistics – Speech Therapy

Speech Therapy Statistics	
Total Expenditures FY 2018-19	$19,449,656
Total Members Utilizing Services FY 2018-19	11,264
Total Billing Providers FY 2018-19	329
Total Rendering Providers FY 2018-19	780

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – Speech Therapy

Unique Procedure Codes	Top 10 as Percent of Total Services Paid
21	76.33%

Procedure Code	Description	Mod 1	Mod 2	Mod 3	Distinct Utilizers	Allowed Units	Paid Dollars
92507	SPEECH/HEARING THERAPY	GN			4,933	97,217	$5,899,169
92507	SPEECH/HEARING THERAPY	GN	96		2,843	41,110	$2,451,719
92507	SPEECH/HEARING THERAPY	GN	59		1,176	25,312	$1,510,271
92507	SPEECH/HEARING THERAPY	GN	TL		1,838	20,066	$1,233,525
92507	SPEECH/HEARING THERAPY				1,158	17,170	$1,019,001
92609	USE OF SPEECH DEVICE SERVICE	GN	59		473	9,531	$710,618
92507	SPEECH/HEARING THERAPY	GN	97		1,337	11,646	$703,052
92523	SPEECH SOUND LANGUAGE COMPREHENSION	GN			2,924	4,004	$617,411
92507	SPEECH/HEARING THERAPY	GN	96	59	653	5,944	$361,526
92507	SPEECH/HEARING THERAPY	96	GN		547	5,610	$340,385

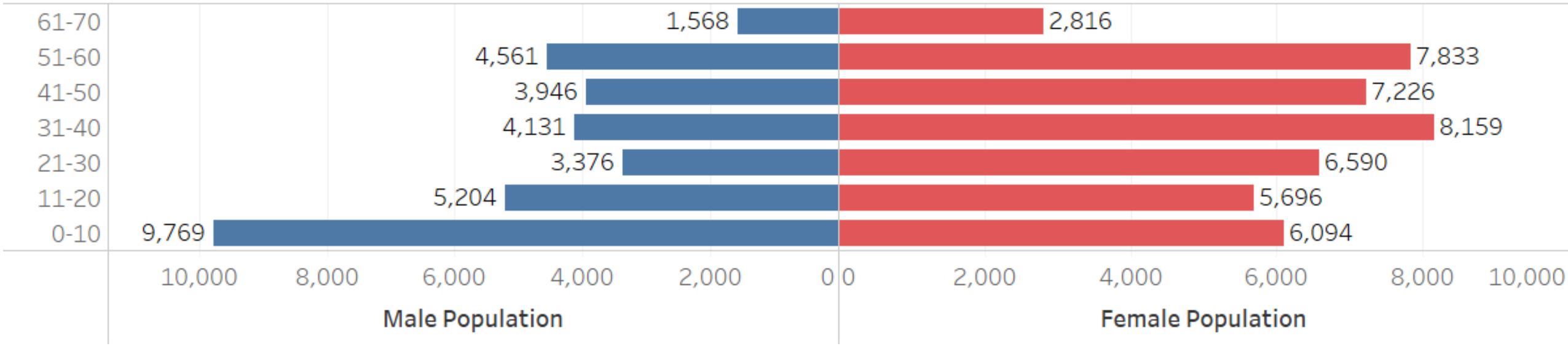
*DRAFT – All Calculations are Preliminary

Questions?

Physical and Occupational Therapy (PT/OT)

- Physical therapy (PT) and occupational therapy (OT) are outpatient services rendered by a physical therapist or an occupational therapist.
- Procedure Codes 97001-97799

Demographics – PT/OT



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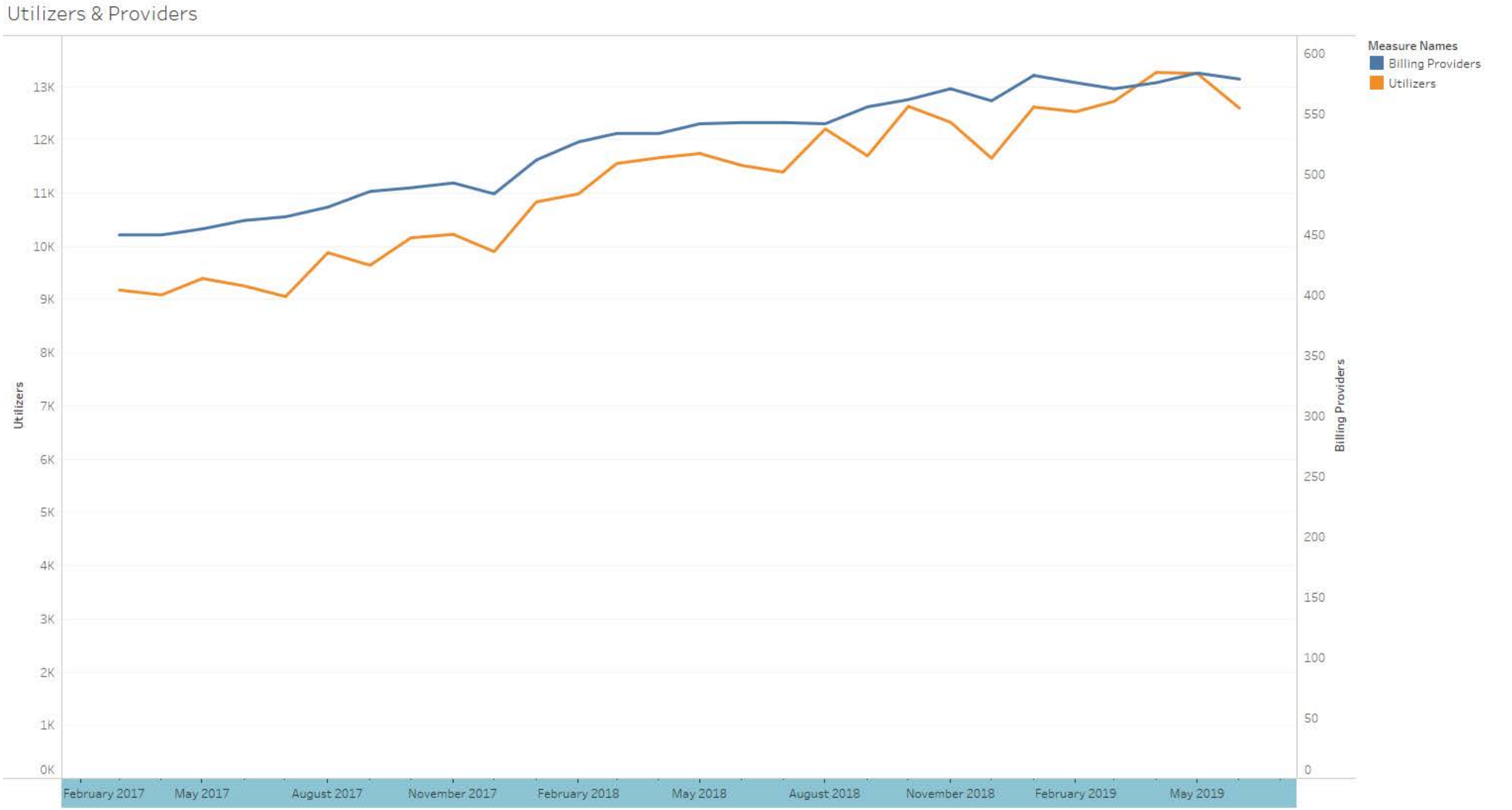
Utilizer & Providers Over Time – PT/OT



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Service Statistics – PT/OT

PT/OT Statistics	
Total Expenditures FY 2018-19	$52,129,747
Total Members Utilizing Services FY 2018-19	42,562
Total Billing Providers FY 2018-19	788
Total Rendering Providers FY 2018-19	2,468

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – PT/OT

Unique Procedure Codes	Top 10 as Percent of Total Services Paid
47	58.46%

Procedure Code	Description	Mod 1	Mod 2	Distinct Utilizers	Allowed Units	Paid Dollars
97530	THERAPEUTIC ACTIVITIES	GO		4,167	191,776	$6,046,244
97110	THERAPEUTIC EXERCISES	GP		21,712	202,700	$5,965,667
97140	MANUAL THERAPY 1/> REGIONS	GP		19,918	168,188	$4,655,788
97112	NEUROMUSCULAR REEDUCATION	GP		11,256	123,004	$3,771,820
97530	THERAPEUTIC ACTIVITIES	GP	59	8,822	65,856	$2,123,651
97530	THERAPEUTIC ACTIVITIES	GO	96	1,830	66,032	$2,053,363
97530	THERAPEUTIC ACTIVITIES	GP		5,568	56,652	$1,797,657
97110	THERAPEUTIC ACTIVITIES	GO		3,316	51,353	$1,515,899
97530	THERAPEUTIC ACTIVITIES	GO	97	1,697	46,467	$1,475,009
97530	THERAPEUTIC ACTIVITIES	GO	TL	1,044	34,176	$1,069,707

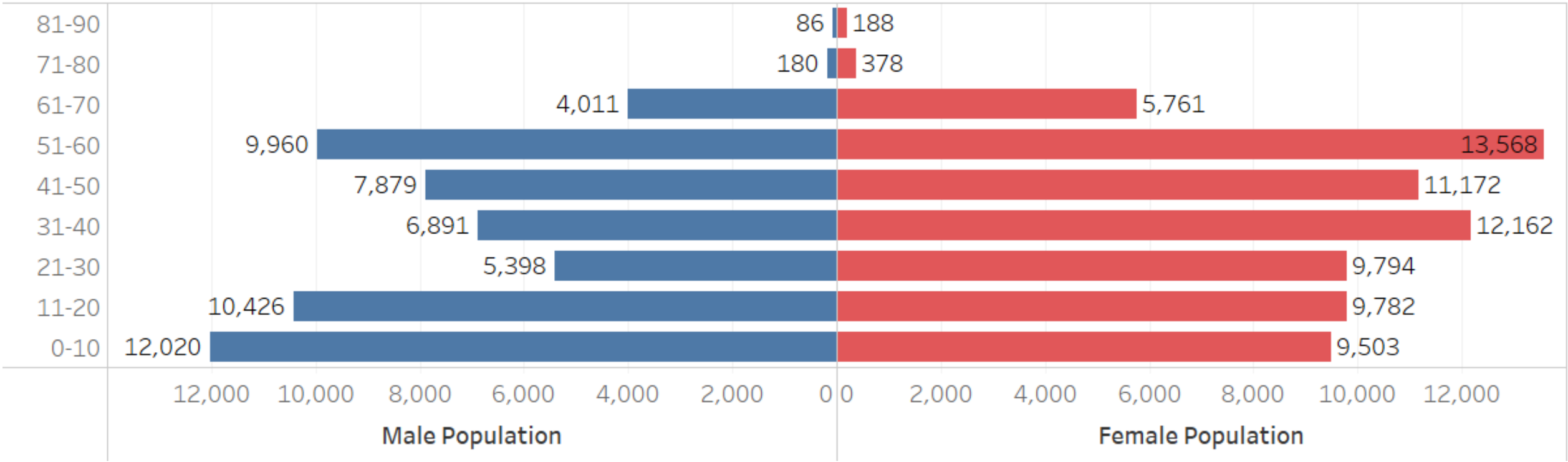
*DRAFT – All Calculations are Preliminary

Questions?

Prosthetics, Orthotics, and Supplies (POS)

- The Prosthetics and Orthotics benefit includes, but is not limited to, items such as breast prostheses, braces, artificial limbs, implants, and orthopedic shoes for diabetic members.
- Supplies must serve a medical purpose but are not intended for repeated use.
- Supply items are items used in active treatment or therapy that are disposable or can be consumed.
- Some examples of supplies that are covered include:
    - Diabetic monitoring supplies;
    - Oral enteral formulas and supplies; and
    - Parenteral supplies.

Demographics - POS



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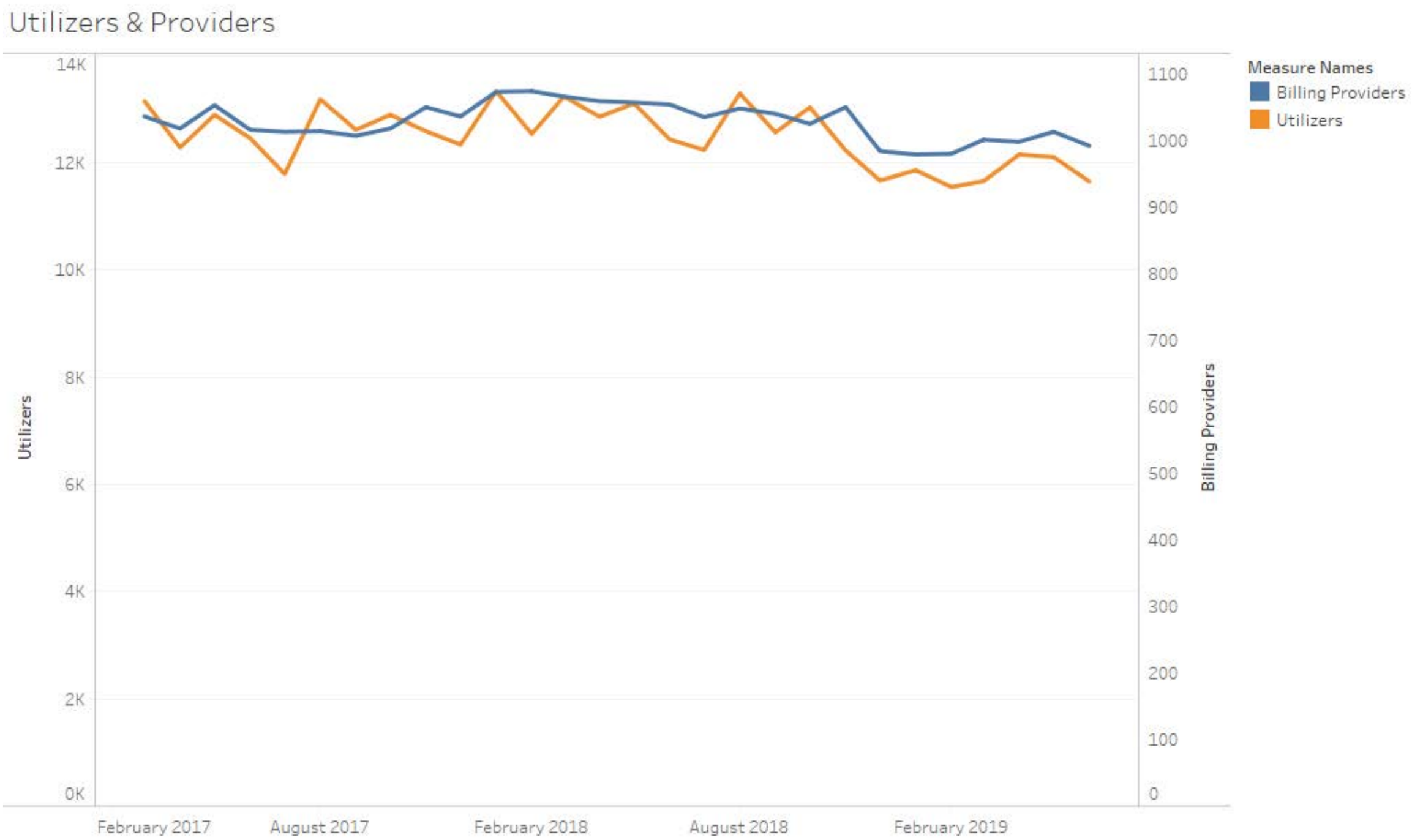
Utilizers & Providers Over Time - POS



*DRAFT – All Calculations are Preliminary

Service Statistics - POS

POS Statistics	
Total Paid Dollars FY 2018-19	$31,530,786
Total Members Utilizing Services FY 2018-19	67,206
Total Billing Providers FY 2018-19	1,377
Total Rendering Providers FY 2018-19	3,591

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – POS

Unique Procedure Codes	Top 10 as Percent of Total Services Paid
731	32.53%

Procedure Code	Description	Mod 1	Mod 2	Distinct Utilizers	Allowed Units	Paid Dollars
A4353	INTERMITTENT URINARY CATHETER			402	368,593	$2,393,655
A4253	BLOOD GLUCOSE/REAGENT STRIPS			13,975	114,033	$2,126,177
L3000	FT INSERT UCB BERKELEY SHELL			2,807	8,413	$1,961,399
A4253	BLOOD GLUCOSES/REAGENT STRIPS	NU		6,276	48,100	$841,349
A7030	CPAP FULL FACE MASK	NU		2,298	4,260	$623,361
S1040	CRANIAL REMOLDING ORTHOSIS			212	226	$586,074
A6211	FOAM DRG>48 SQ IN W/O BRDR			46	15,840	$510,338
L3000	FT INSERT UCB BERKELEY SHELL	LT	RT	702	1,970	$457,623
L1907	AFO SUPRAMALLEOLAR CUSTOM	LT	RT	385	815	$392,744
A4351	STRAIGHT TIP URINE CATHETER			436	291,427	$365,606

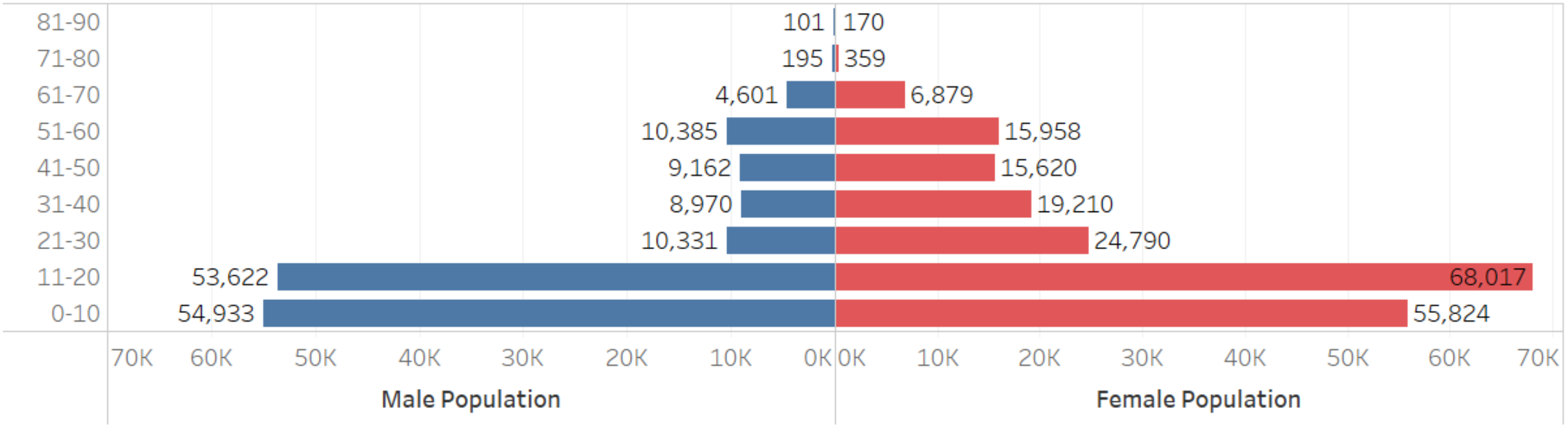
*DRAFT – All Calculations are Preliminary

Questions?

Eyeglasses/Vision

- Benefits for members ages 21 and older:
    - Annual eye examinations and follow-up appointments;
    - Eyeglasses and contact lenses are benefits following eye surgery only; and
    - Ocular prosthetics.
- Benefits for members ages 20 and younger:
    - Annual eye examinations and follow-up appointments are a benefit;
    - Eyeglasses (one or two single or multifocal vision clear plastic or polycarbonate lenses with one frame);
    - Glasses dispensed by an optician when ordered by an ophthalmologist or optometrist;
    - Replacement or repair of frames or lenses, not to exceed the cost of replacement;
    - Contact lenses (must be medically necessary); and
    - Ocular prosthetics.

Demographics – Eyeglasses/Vision



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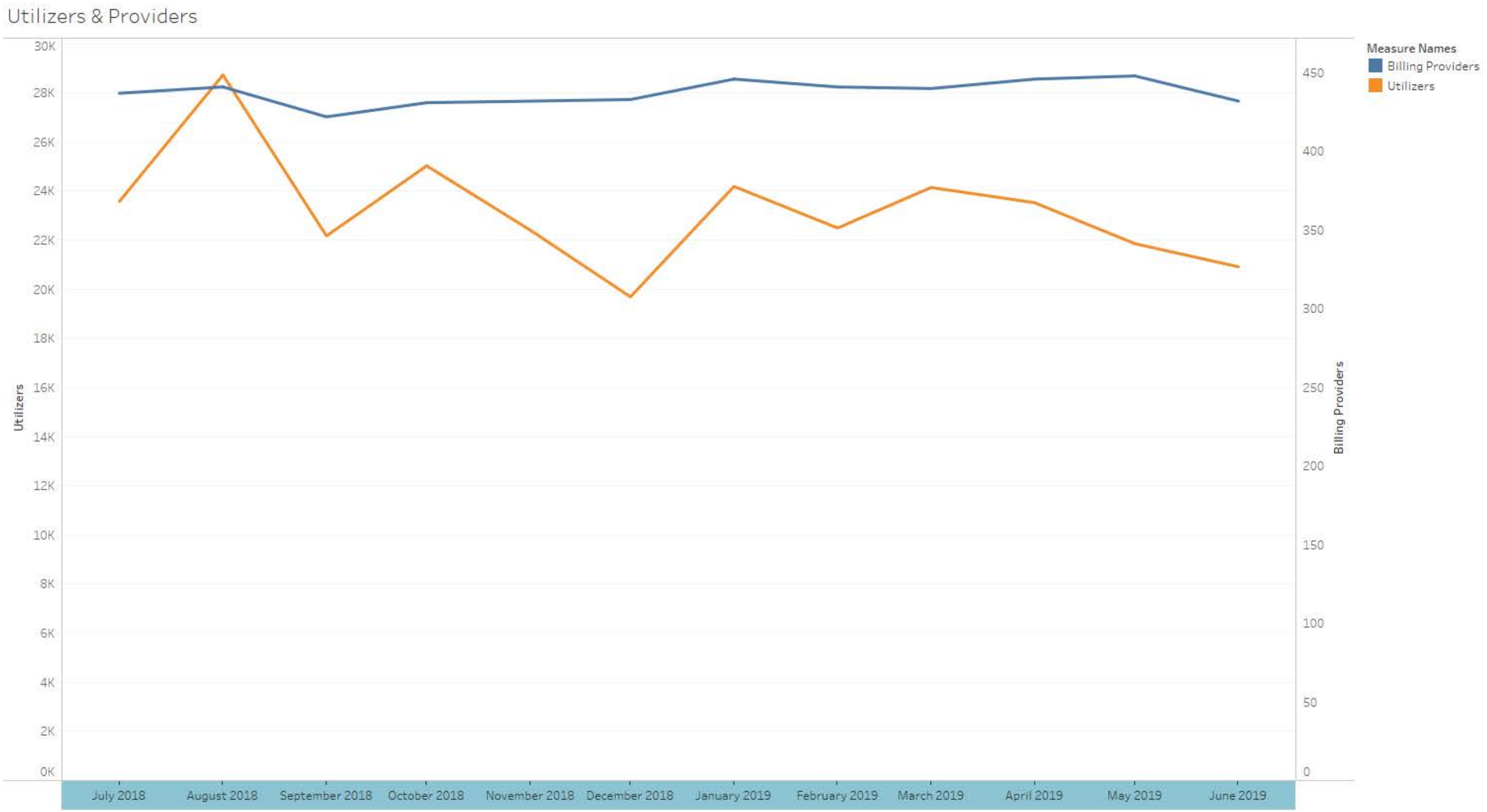
Utilizers & Providers Over Time – Eyeglasses/Vision



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Service Statistics – Eyeglasses/Vision

Eyeglasses/Vision Statistics	
Total Expenditures FY 2018-19	$55,139,530
Total Members Utilizing Services FY 2018-19	209,019
Total Rendering Providers FY 2018-19	544
Total Billing Providers FY 2018-19	1,230

*DRAFT – All Calculations are Preliminary

Top 10 Procedure Codes – Eyeglasses/Vision

Unique Procedure Codes	Top 10 as Percent of Total Services Paid
108	87.09%

Procedure Code	Description	Distinct Utilizers	Allowed Units	Paid Dollars
V2410	LENS VARIABLE ASPHERICITY SING	52,710	160,008	$11,129,761
92014	EYE EXAM & TX ESTAB PT 1/>VST	102,220	108,054	$10,983,838
92004	EYE EXAM NEW PATIENT	83,603	85,521	$10,198,033
V2020	VISION SERVICES FRAMES PURCHASES	99,568	155,972	$5,539,544
V2103	SPHEROCYLINDER 4.00d/12-2.00D	47,611	122,178	$2,841,004
92340	FIT SPECTABLES MONOFOCAL	87,485	144,424	$2,320,681
V2784	LENS POLYCARB OR EQUAL	85,861	262,149	$1,832,776
V2100	LENS SPHER SINGLE PLANO 4.00	25,909	58,103	$1,181,219
92012	EYE EXAM ESTABLISHED PATIENT	9,844	14,414	$1,018,442
V2104	SPHEROCYLINDER 4.00D/2.12-4D	13,057	33,441	$977,419

*DRAFT – All Calculations are Preliminary

Questions?

Rate Comparison and Access to Care Metrics

& Methodology

Presented by: Eloiss Hulsbrink, Jeff Laskey, and Matt Wellens

Base Data - Validation

- *Claims data from March 1, 2017 – June 30, 2019*
- *March 1, 2017 – June 30, 2018 data is used for validation and adjustment purposes only*
- *Data from FY 2018-19 will be utilized in the analysis to base results on the most recent experience*
- *Verify the consistency of the data for paid amounts and utilization over time*
- *Incurred but not Reported (IBNR) Analysis*

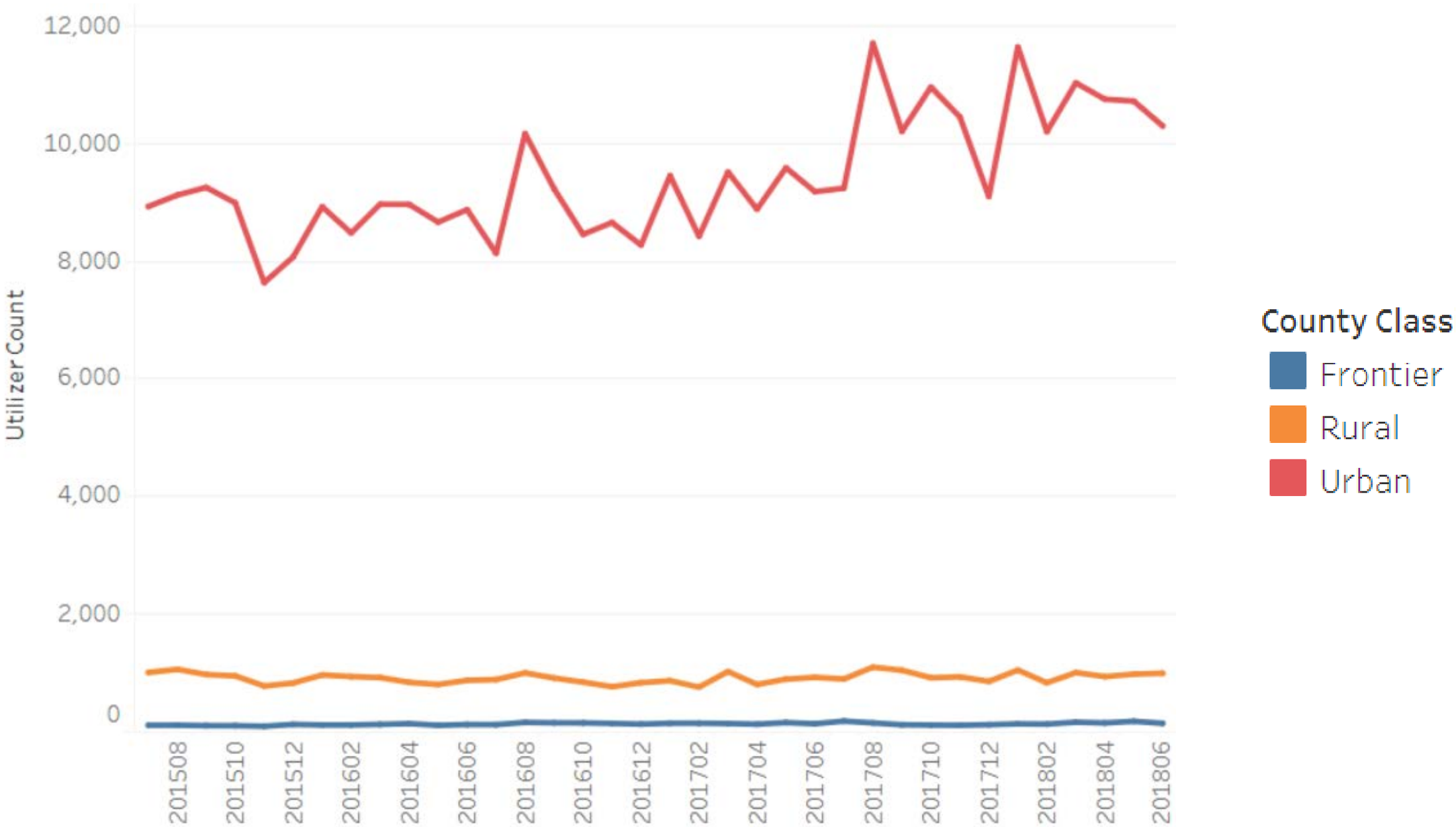
Base Data - Exclusions

- *Match against Enrollment file once available to increase data reliability*
- *Reprice using latest Health First Colorado rates and a comparable benchmark*
- *Evaluate Colorado vs. Benchmark*

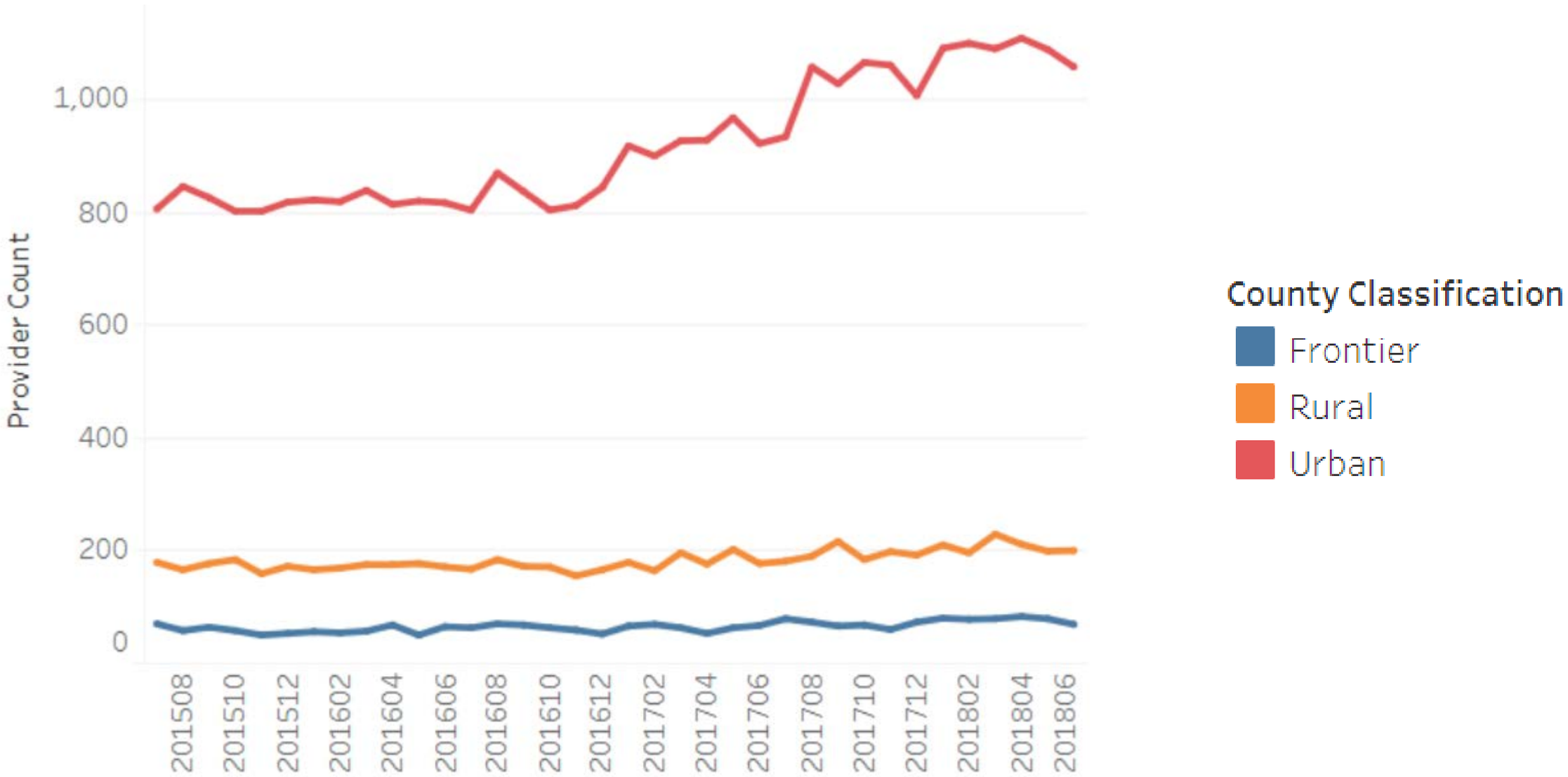
Access to Care Analyses

- ***Over Time:*** *Utilizers, Providers, and Utilizers per Provider (Panel Size)*
- ***FY 2018-19:*** *Member to Provider Ratios, Utilizer Density, Penetration Rate, Drive Time Estimates*

EXAMPLE: FFS Behavioral Health – Distinct Utilizers Over Time

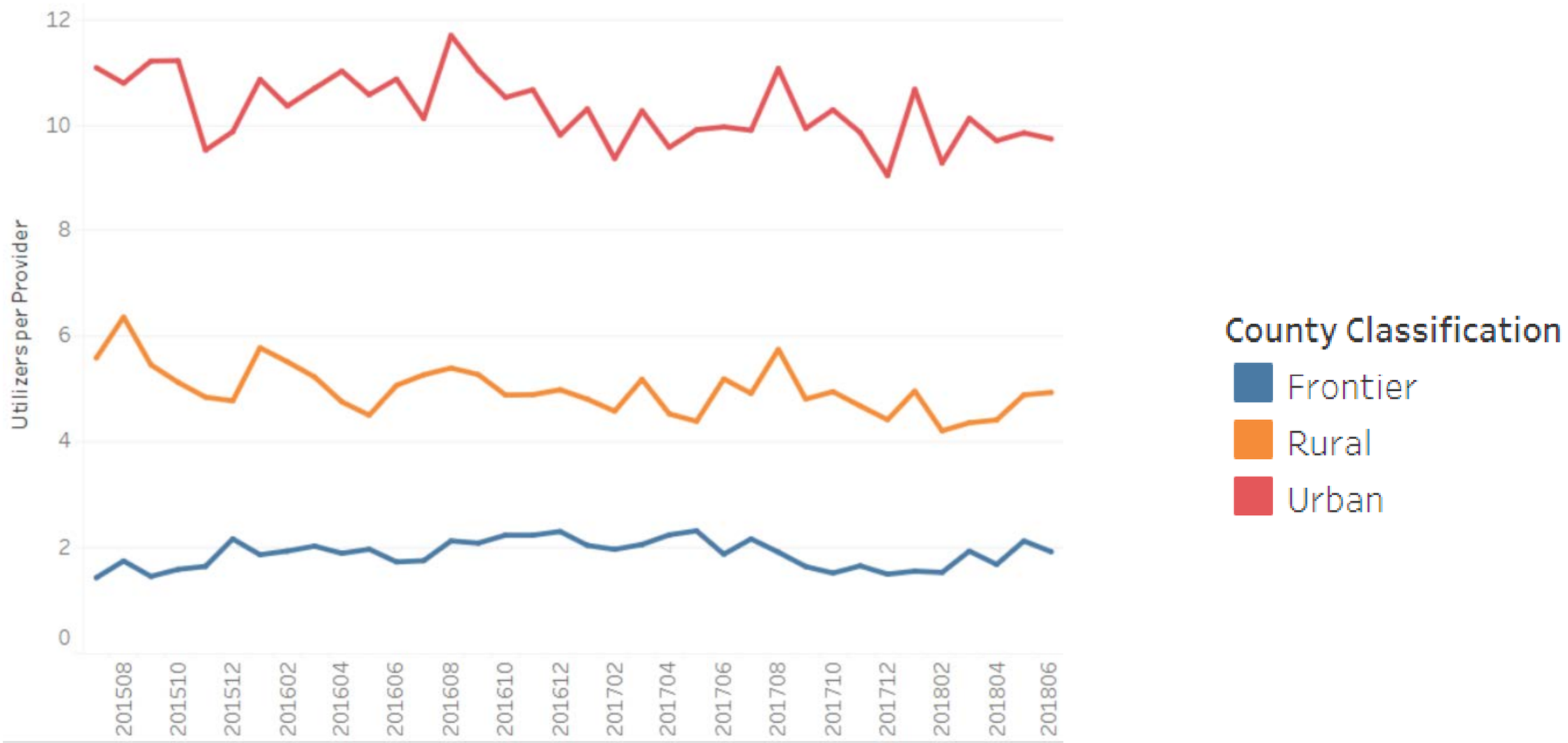


EXAMPLE: FFS Behavioral Health – Active Providers Over Time



EXAMPLE: FFS Behavioral Health Utilizers Per Provider (Panel Size)

- Panel Size estimates average Medicaid members seen per provider, by geographic area

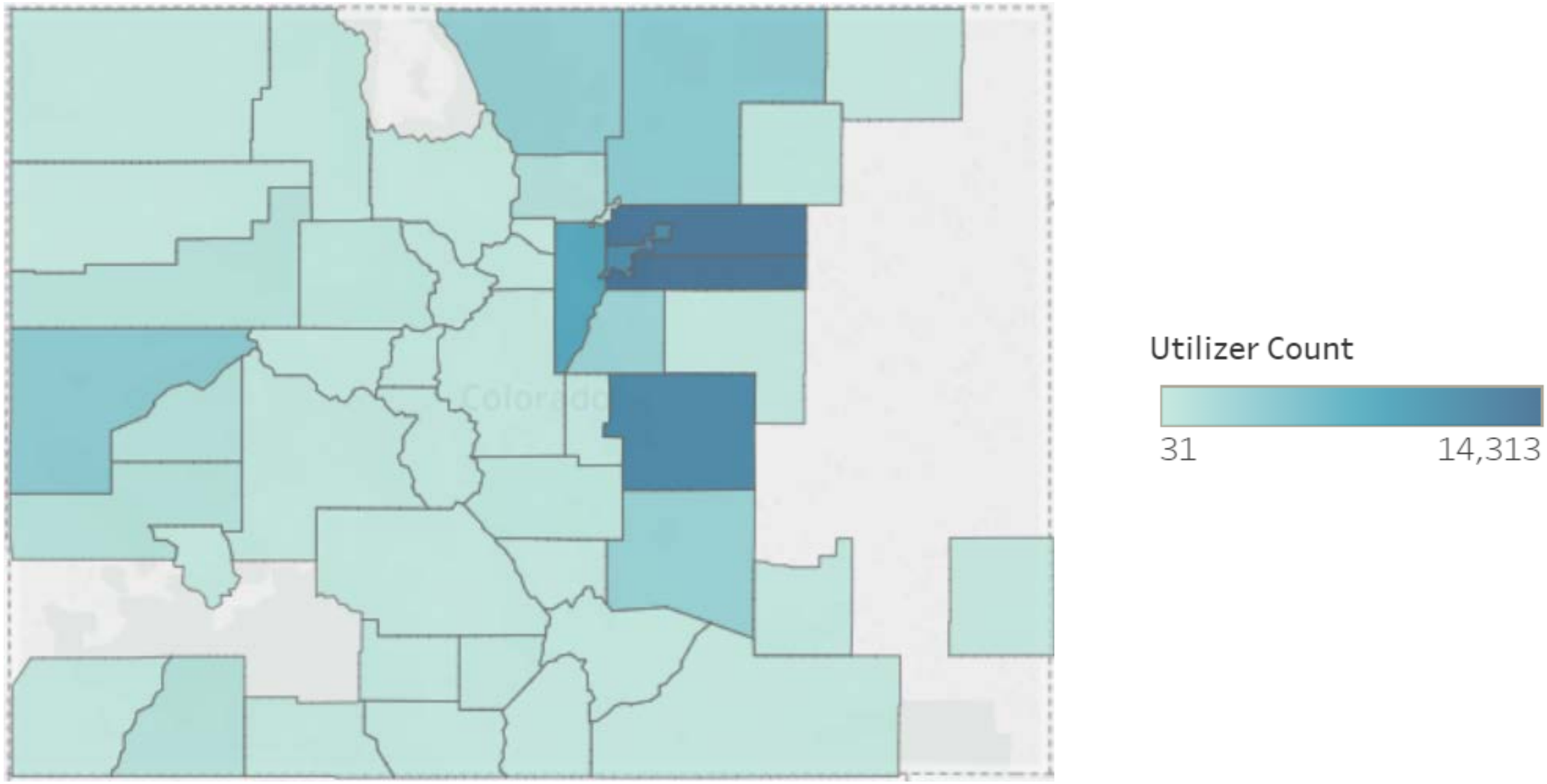


EXAMPLE: FFS Behavioral Health Member to Provider Ratio

- Expressed as providers per 1,000 members
- Normalizing, or standardizing, per 1,000 members allows for comparisons across areas with large differences in population size

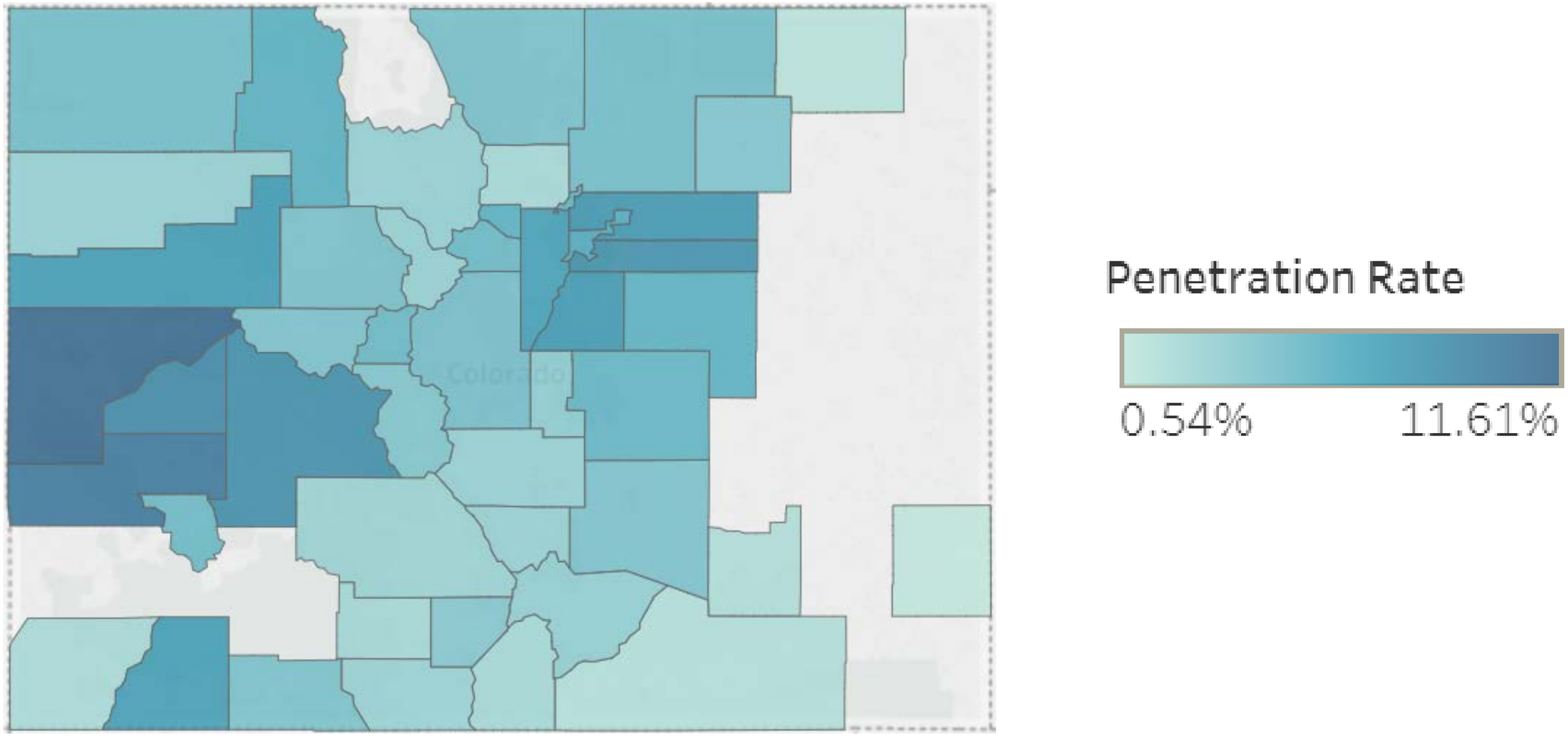
Region	FY 2018-19 Providers	FY 2018-19	Providers per 1,000 Members
Frontier	307	41,742	7.35
Rural	599	162,003	3.70
Urban	2,097	1,217,439	1.72
Statewide	**2,245**	**1,408,747**	**1.59**

EXAMPLE: FFS Behavioral Health Utilizer Density FY 2017-18 Map

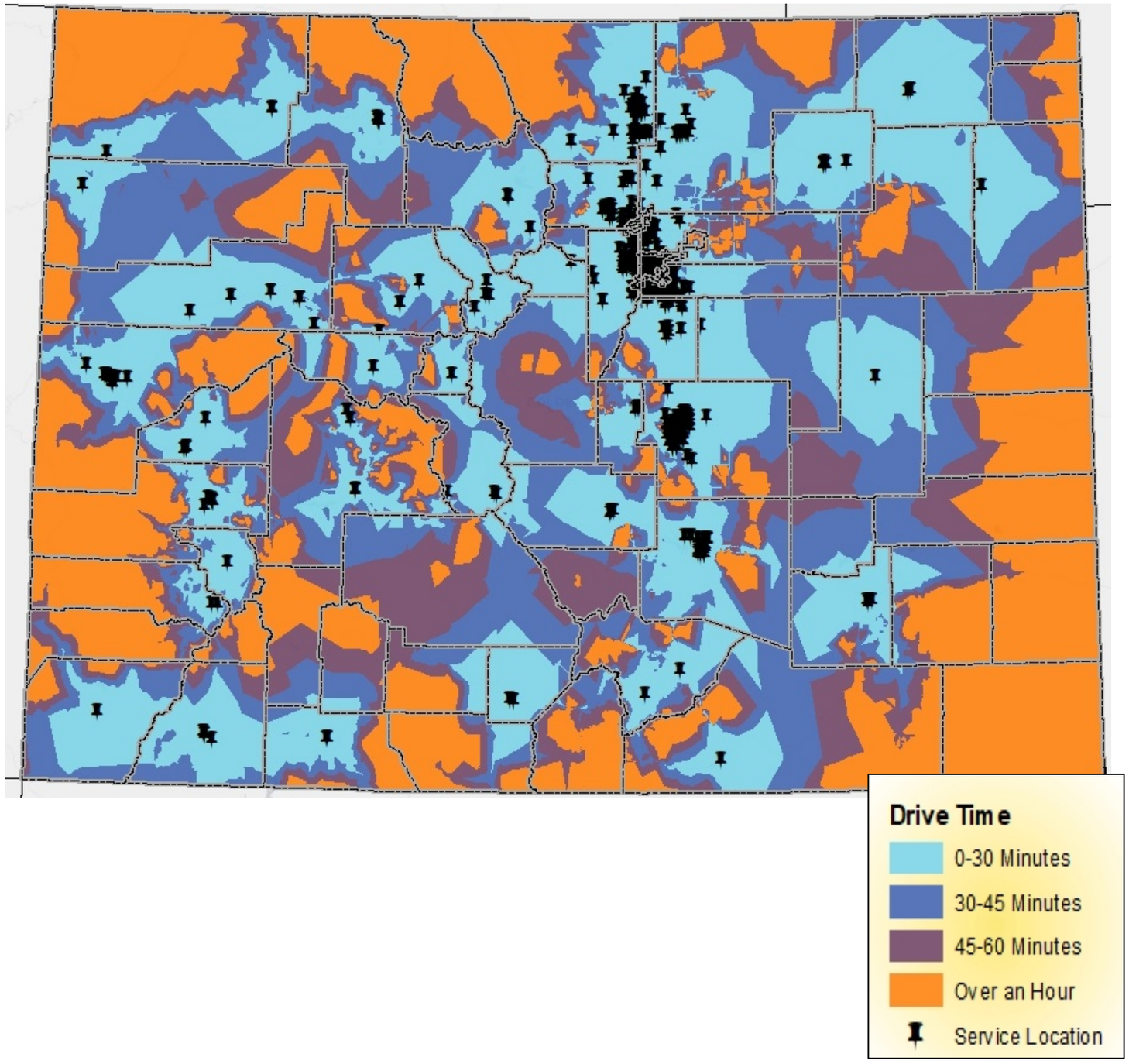


EXAMPLE: FFS Behavioral Health – Penetration Rate by Member County

- Penetration Rates estimate the share of total Medicaid enrollees that received this service in FY2017-18



EXAMPLE: FFS Behavioral Health ArcGIS Map



Drive Time	Percent of Utilizers by Drive Time
0-30 Minutes	96%
30-45 Minutes	3%
45-60 Minutes	<1%
Over an Hour	<1%
Total	100%

Year Four Access to Care Analyses

- Examples of time and distance standards:

County Type	Urban		Rural		Frontier	
Method of Measurement (from member residence)	Max Dist. (Miles)	Max Time (Min.)	Max Dist. (Miles)	Max Time (Min.)	Max Dist. (Miles)	Max Time (Min.)
Primary Care	30	30	45	45	60	60
Gynecology, OB/GYN	30	30	45	45	60	60

- Examples of Medicare Advantage minimum member to provider ratios (providers per 1,000 beneficiaries) using CMS county classifications:

Specialty	CMS Geographic Type				
	Large Metro	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	1.67	1.67	1.42	1.42	1.42
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
General Surgery	0.28	0.28	0.24	0.24	0.24

Questions?

Data Analysis Considerations – MPRRAC Discussion and Stakeholder Comment

- Scope of discussion

- If you have additional comments that are not within the scope of this meeting, they can be sent to HCPF_RateReview@state.co.us.

- Ground rules reminder

Next Steps and Announcements

- Rules of Governance
- Next meeting
- Doodle Poll to schedule the rest of the 2020 MPRRAC meetings.
- Communications with Department
    - Email is *preferred* method of communication.

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Thank You!