Medicaid Provider Rate Review Advisory Committee Meeting

Presented by: Eloiss Hulsbrink

September 18, 2020
9:00 AM – 12:00 PM

Our Mission

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

Agenda

Introductions	9:00 a.m.
Review Agenda and Meeting Logistics	9:05 a.m.
Meeting Minutes	9:10 a.m.
MPRRAC Vice Chair	9:15 a.m.
Guiding Principles	9:25 a.m.
Working Recommendations for Year Five Services: • Pediatric Personal Care • Home Health • Private Duty Nursing • Pediatric Behavioral Therapy	9:30 a.m.
Break	*10:40 a.m.*
Data Analysis Preliminary Results for Year Five Services: • Speech Therapy • Physical/Occupational Therapy • Prosthetics, Orthotics, and Supplies • Vision	10:50 a.m.
Next Steps and Announcements	11:55 a.m.
Adjourn	12:00 p.m.

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.

Committee Appointments

Eloiss Hulsbrink

Meeting Minutes

February 21, 2020

Meeting Minutes

June 19, 2020

MPRRAC Vice-Chair

Nominations

Guiding Principles

Presented by: Eloiss Hulsbrink & Chair

Stakeholder Engagement Guiding Principles

The Department will:

- Thoroughly and thoughtfully evaluate all questions and feedback.
- Identify what feedback can be incorporated now or potentially in the future.
- Transparently communicate the outcomes of feedback and questions.
- Refer individuals to appropriate Department resources for out-of-scope topics.

Rate Review Guiding Principles

The Department will:

- Thoroughly and thoughtfully evaluate services within and across benefits.
- Strive to promote member access to quality care and provider retention.
- Be guided by **recent data analyses and evidence-based research** and best practices.
- Work to identify methods to collect meaningful data when there an absence of evidence or when conflicting evidence or feedback exists.

MPRRAC Guiding Principles

- Do not reinvent the wheel (e.g., if an established rate structure exists, consider using it).
- Support recommendations that work towards providing services in the least restrictive and most cost-effective environment.
- Develop methodologies to address geographic differences.
- Strive to reimburse for costs of hard goods.

MPRRAC Guiding Principles

- Discussed as potential addition to MPRRAC guiding principles at the last meeting:

- Benchmark for rates compared to other states' Medicaid rates should be 100%, not 80% to 100% of the rate.

Key Considerations

- The benchmark is an *average* of other states' rates, not a single rate.
- Rate setting projects that evaluate all factors that impact Colorado Medicaid providers.
- While comparing to an average provides an overall picture of how we compare to other Medicaid programs, there are often other factors that impact Medicaid rates that must be considered, such as:
- state-specific initiatives;
  - population size, density, and demography;
  - geography;
  - state budgets/funding availability; and
  - wages/standard of living.

MPRRAC Guiding Principles

- Discussed as potential addition to MPRRAC guiding principles at the last meeting:

- Benchmark for rates compared to other states' Medicaid rates should be 100%, not 80% to 100% of the rate.

- Committee Vote

Year Five Services Working Recommendations

Presented by: Eloiss Hulsbrink

Pediatric Personal Care (PPC)

- Analyses suggest that PPC payments at 134.35% of the benchmark were sufficient to allow for member access and provider retention.
- Colorado as a percentage of five other states' Medicaid rates ranged from 109.48%-140.57% of the benchmark.

PPC Key Considerations

Stakeholder Feedback

- There is a reportedly low availability of active providers of PPC services for Medicaid members.
- Low wages are paid to PPC caregivers.

PPC Key Considerations

Additional Considerations

- The PPC benefit only refers to State Plan Pediatric Personal Care services for members under the age of 20 that qualify for one of 17 personal care tasks.
- PPC services are performed by a non-medically trained caregiver in the member's home.
- Members seeking PPC services are often directed by home health agencies to Long-Term Home Health (LTHH) services provided by licensed home health agencies.
- PPC service rates were compared to an average of five other states' Medicaid rates; Colorado, Florida, and Texas are the only states that reimburse for pediatric-specific personal care services.
- The total number of billing providers does not represent the total number of caregivers employed by agencies providing PPC services.
- Provider billing locations do not encompass all brick-and-mortar agency locations.

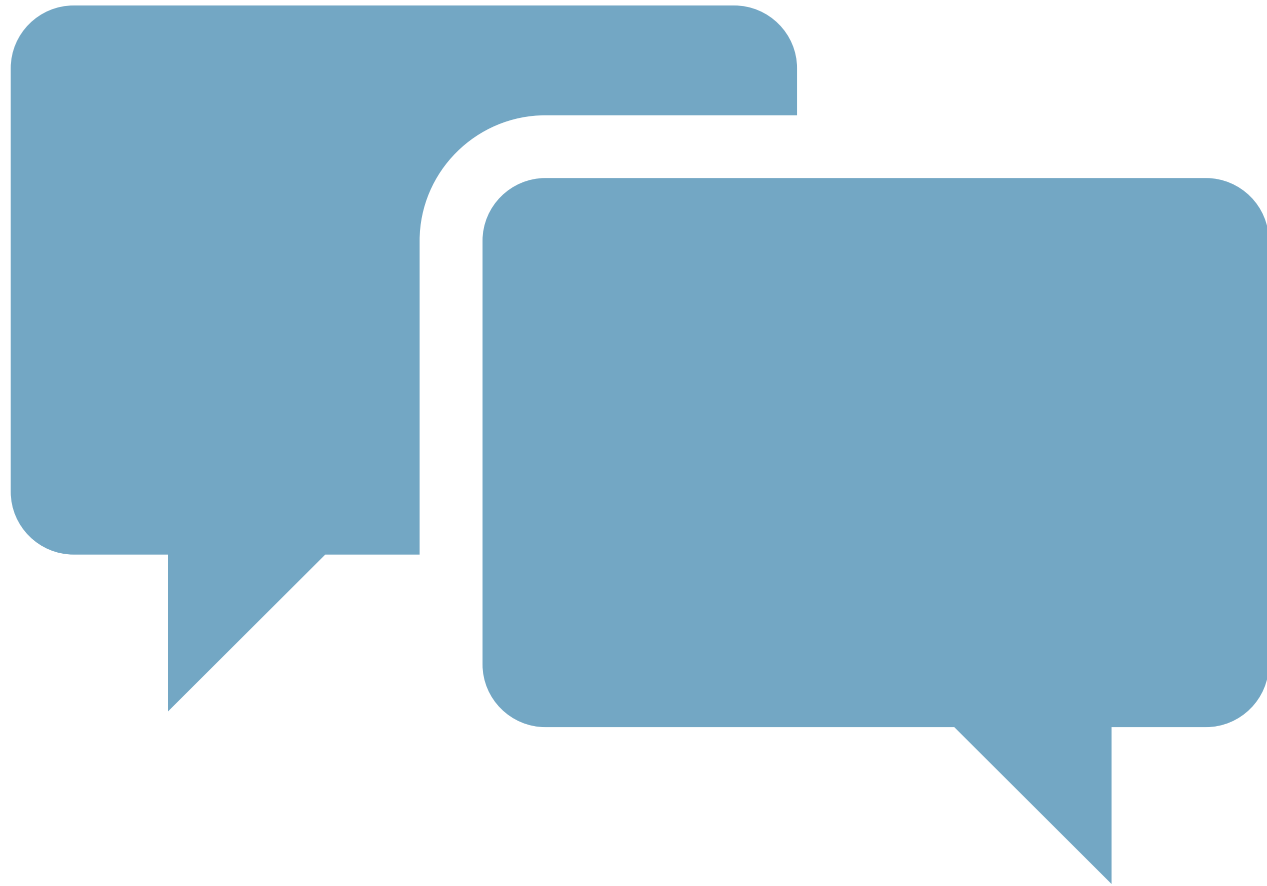
PPC Working Recommendations

The Department recommends:

- continuing outreach efforts to Home and Community-Based Services (HCBS) class B licensed providers to alert them that PPC state plan services is allowable and billable by license type.

Questions?

Stakeholder Comments



Committee Discussion

Home Health

- Analyses suggest home health payments at 101.72% of the benchmark were sufficient to allow for member access and provider retention.
- The individual rate ratios were 76.04%-348.53% of the benchmark.

Home Health Key Considerations

Stakeholder Feedback

- If more home health caregivers were available, more members could leave the hospital setting earlier.
- The home health fixed rate does not have a minimum requirement for services.
- Agencies are having difficulty hiring caregivers; providers suggest the current rate is the reason.
- Aligning with Medicare is insufficient due to the short-term nature of Medicare Home Health services.
- Rates should be set at 90% of the Medicare Low Utilization Payment Adjustment (LUPA) rates for home health services.
- Electronic Visit Verification (EVV) requirements will discourage smaller providers from delivering Home Health services.

Home Health Key Considerations

Additional Considerations

- Unit values vary from state-to-state; Colorado visits are either one hour or two and a half hours per visit, compared to other states that reimbursed based on various unit values.
- Colorado is one of four states with both a home health basic and extended rate.
  - Colorado Medicaid pays $38.12 for the home health basic rate, which is for the initial one-hour visit; this rate is 76.04% of the benchmark average; and
  - the lower basic rate is balanced out with additional reimbursement for visits lasting more than one-hour with the home health extended rate, which pays an additional $11.39 for each extended unit of 15-30 minutes; this rate is 348.53% of the benchmark.
- A previous assessment by the Department concluded that LUPA is not an appropriate comparator for home health rates due to differences in client eligibility, utilizer characteristics, and unit designations.
- The Joint Budget Committee (JBC) allocated funding to the Department to bring rates to 30% of Medicare LUPA, stating that funding would be provided in the following two years to bring rates to 60% and then 90% of Medicare LUPA rates. However, the Department only received funding for the first year.

Home Health Key Considerations

Additional Considerations

- EVV is a federal requirement; the Department has worked closely with stakeholders to ensure the option of a state system that meets the needs of providers and members, while also complying to the requirements established by the Centers for Medicare and Medicaid (CMS).
- Electronic Visit Verification (EVV) is now live; EVV will be tied to claims starting in January 2021 and data will be available for future years of review.
- It should be noted there will be a live-in caregiver exemption, which may limit the data the Department receives from EVV.

Home Health Key Considerations

Additional Considerations

- The Department received information that some home health agencies merged with other agencies, which led to a perceived decrease in active providers, but did not have an impact on the actual number of agencies providing home health services; therefore, access was not negatively impacted.
- Total number of billing providers does not represent the total number of caregivers employed by home health agencies.
- Provider billing locations do not encompass all brick-and-mortar agency locations.
- Home health services received 1% Across-the-board (ATB) increases in July 2018 and July 2019.
- In 2017, the following home health services received a Targeted Rate Increase (TRI) of 6.01-6.02%:
  - Registered Nurse (RN)
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy

Home Health Working Recommendations

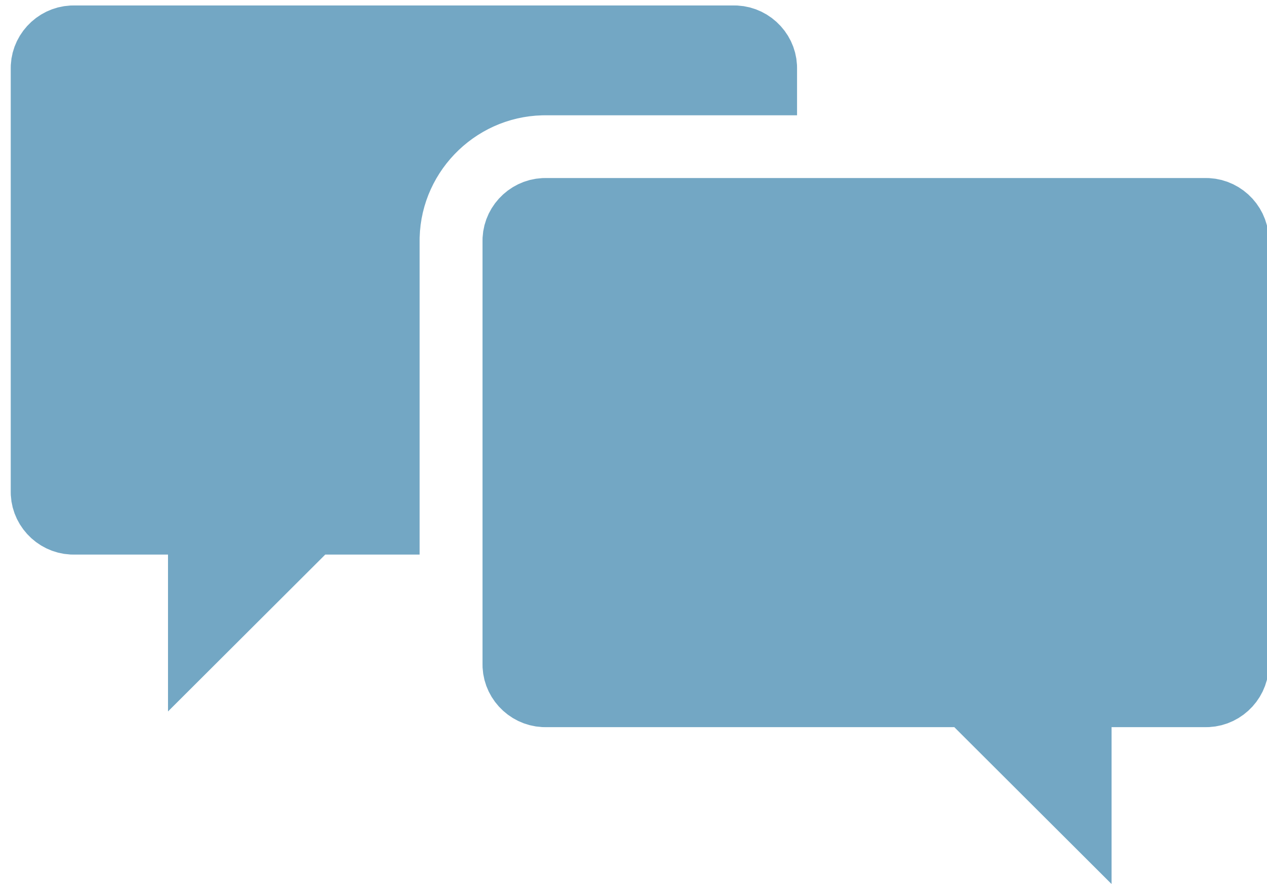
The Department recommends:

- further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health speech therapy rates and outpatient speech therapy rates); and

- further evaluating the development, implementation, and operationalizing minimum duration requirement(s) for home health visits.

Questions?

Stakeholder Comments



Committee Discussion

Private Duty Nursing (PDN)

- Analyses suggest that PDN service payments at 98.15% of the benchmark were sufficient to allow for member access and provider retention.
- Individual rate ratios ranged from 74.08%-102.03% of the benchmark.

PDN Key Considerations

Stakeholder Feedback

- Licensed Practical Nurse (LPN) rates are too low to be competitive; concerns were raised regarding untapped potential in recruiting LPNs for PDN providers servicing Colorado Medicaid members.

- Data used in the rate comparison was outdated.

PDN Key Considerations

Additional Considerations

- Rate comparison data for the 2020 Medicaid Provider Rate Review Analysis Report uses claims information from FY 2018-19 to determine accurate utilization levels and estimate expenditures; however, data is repriced using the most recently available fee schedules (e.g., July 2019 or January 2020).
- LPN received 7.24% a TRI in 2017; data from before and after the TRI showed utilization was not affected.
- The Department's rate setting process considers operational costs, which includes costs such as staff wages, benefits, rental and utility costs, etc. Cost reporting, which is not available to the Department, would further inform rate setting efforts; however, the Department has not been offered these reports.

PDN Key Considerations

Additional Considerations

- Individually, the LPN rate is 96.98% of other states' average Medicaid rate and the RN rate is 102.03% of other states' average Medicaid rate.
- Unit values for PDN services in Colorado are based on one hour per unit, compared to other states that reimburse based on various unit values (e.g., 15-minute increments, untimed visits, etc.).
- Total number of billing providers does not represent the total number of caregivers employed by agencies providing PDN services.
- Provider billing locations do not encompass all brick-and-mortar agency locations.

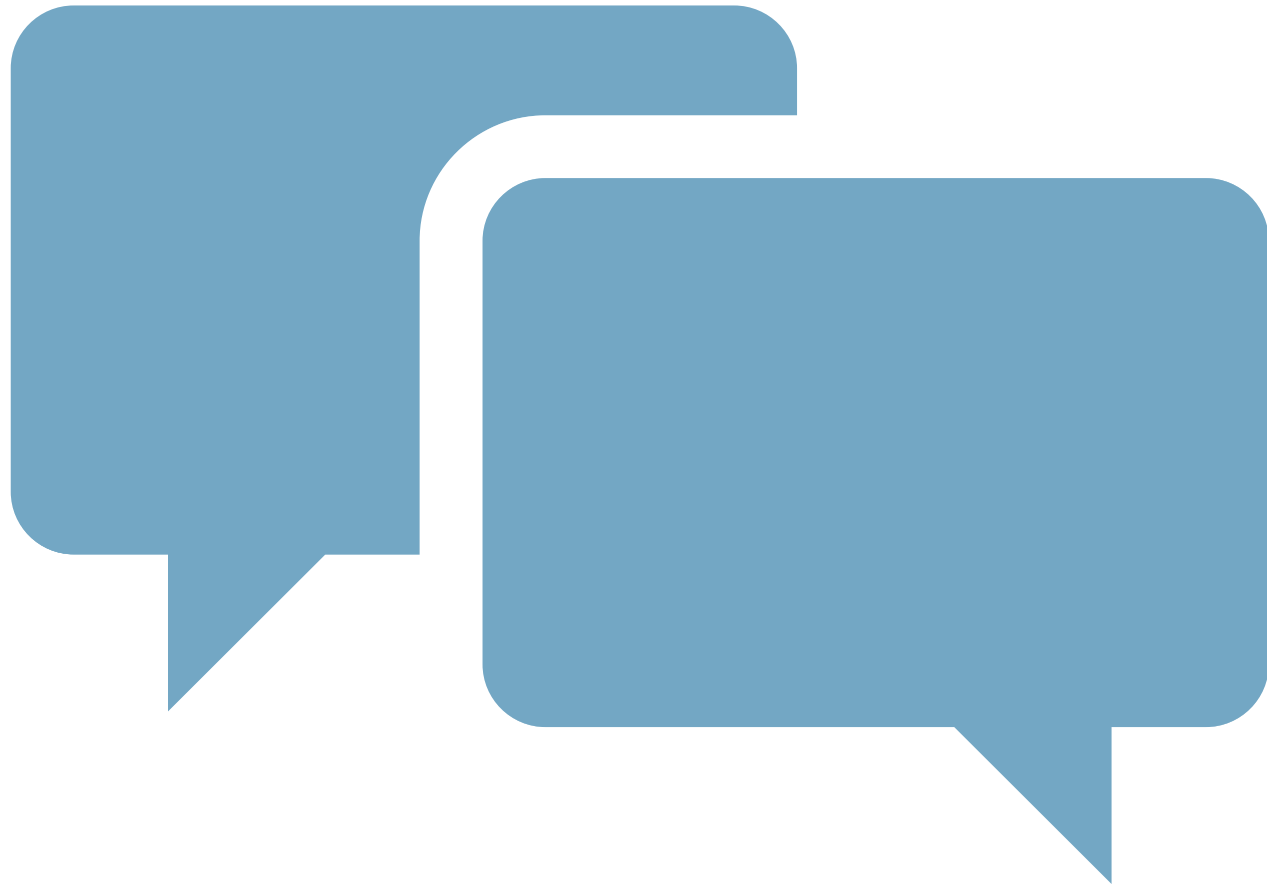
PDN Working Recommendations

The Department recommends:

- further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health RN/LPN rates and PDN RN/LPN rates).

Questions?

Stakeholder Comments



Committee Discussion

Pediatric Behavioral Therapy (PBT)

- Analyses suggest that PBT payments at 92.90% of the benchmark were sufficient to allow for member access and provider retention.

- Individual PBT rate ratios ranged from 85.99%-94.31% of the benchmark.

PBT Key Considerations

Stakeholder Feedback

- The impact of transitioning PBT from a waiver service to an EPSDT service was a perceived rate cut for providers.
- The increased complexity of requirements for EPSDT providers is impacting provider retention.
- There is a disruption of services when members reach age 21 because they must transition from EPSDT services to waiver services.

PBT Key Considerations

Additional Considerations

- The reimbursement rates for PBT services remained consistent in the transition from waiver to EPSDT services.
- There are currently 431 providers now rendering PBT services, compared to only 88 providers that were enrolled as Behavioral Services providers through the Children's Extensive Supports (CES) and Children with Autism (CWA) waivers.
- Colorado is currently the only state offering pediatric-specific rates for behavioral therapy.
- Members should work with their Case Management Agency (CMA) to transition services when approaching 21 years of age.
- There are no additional requirements necessary for enrolled providers to provide EPSDT services.
- Prior Authorization Request (PAR) processes are similar across services that require PARs.

PBT Working Recommendations

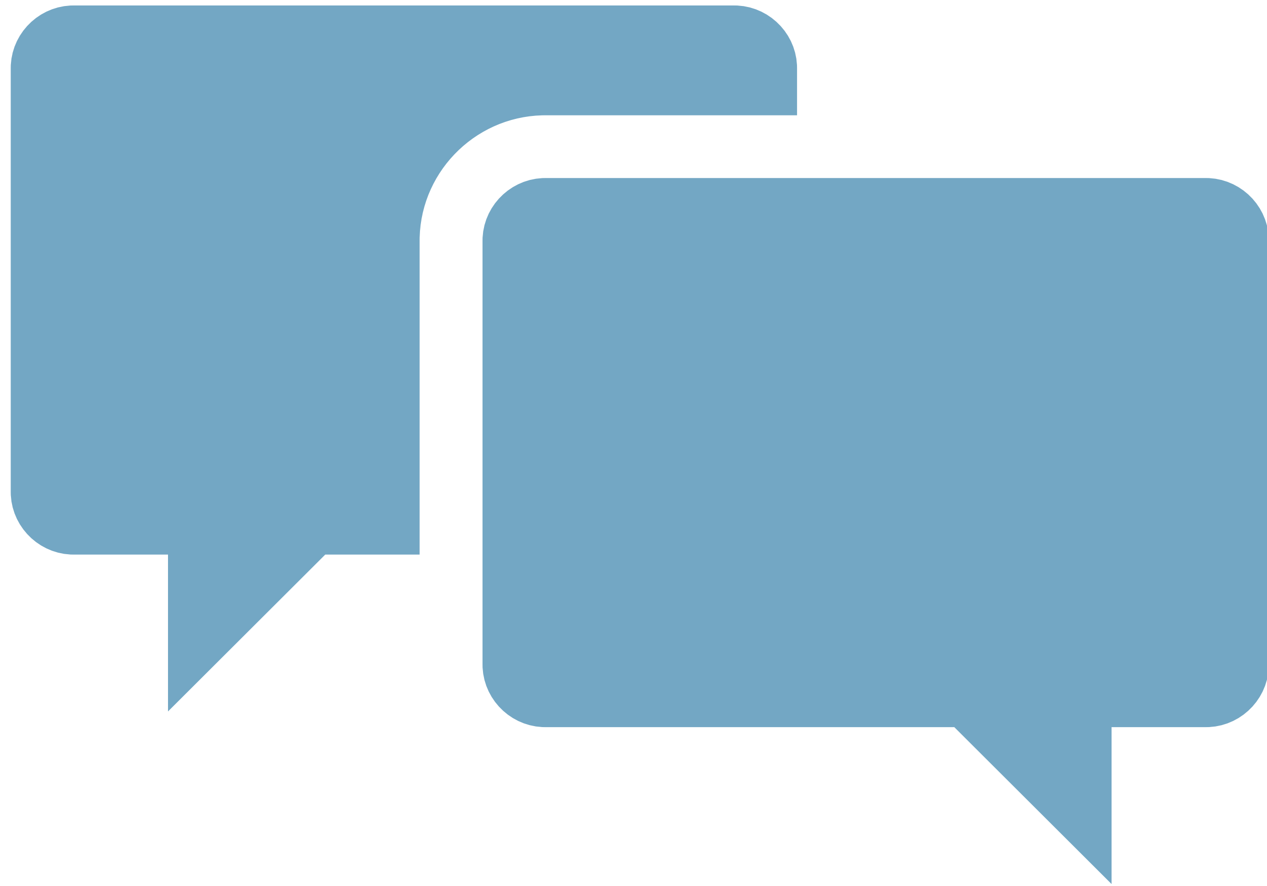
The Department recommends:

- evaluating seeking federal approval to make PBT a State Plan benefit; and

- continuing to support internal efforts to recruit and retain providers of PBT services and promote access to care.

Questions?

Stakeholder Comments



Committee Discussion

Speech Therapy

- Analyses are inconclusive to determine if Speech therapy payments at 73.51% of the benchmark were sufficient to allow for member access and provider retention.

- Speech Therapy individual rate ratios ranged from 16.82%-107.20% of the benchmark.

*DRAFT – All Calculations are Preliminary

Speech Therapy Key Considerations

Stakeholder Feedback

- Speech Therapy rates are not sufficient to offer competitive staff wages, retain specialized providers, or cover overhead and administration costs.
- Rates are significantly lower than home health speech therapy rates, even though both provider groups require similar levels of training and expertise.
- The feeding therapy rate is very low.

Speech Therapy Key Considerations

Additional Considerations

- Utilization trends in data indicate migration of services from individual providers to home health agencies, who provide a wider range of services for individuals needing more comprehensive home health care.
- Home health agencies have more requirements and administrative costs compared to individual providers, which are factored into home health rates.
- Most therapy service visits include provision of more than one service.
- Speech therapy rates could not be rebalanced in a budget-neutral manner as previously recommended in the 2017 Medicaid Provider Rate Review Recommendation Report; rebalancing would have required additional funds.

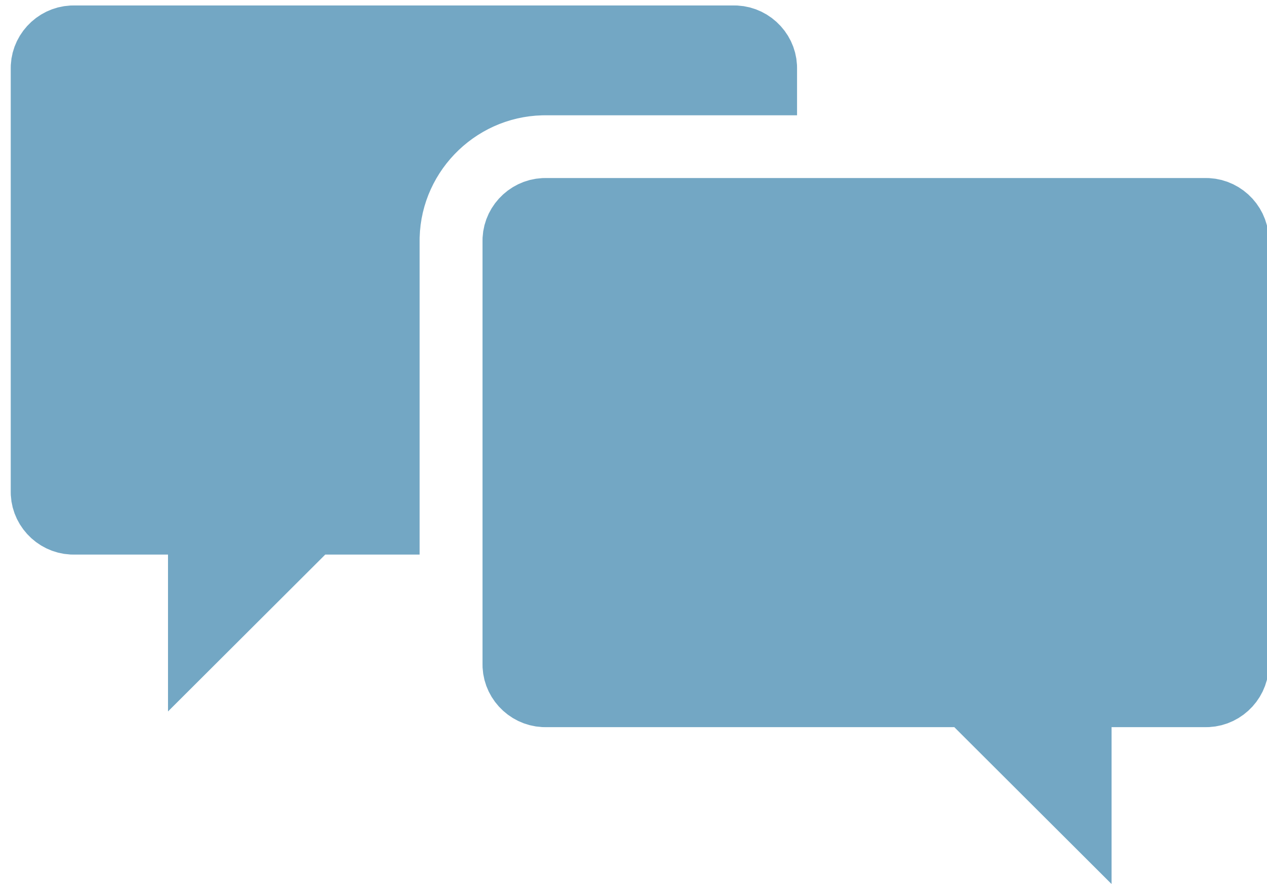
Speech Therapy Working Recommendations

The Department recommends:

- rebalancing speech therapy rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.
- further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health speech therapy rates and outpatient speech therapy rates).

Questions?

Stakeholder Comments



Committee Discussion

Physical and Occupational Therapy (PT/OT)

- Analyses suggest PT/OT payments at 86.41% of the benchmark were sufficient to allow for member access and provider retention.
- PT/OT individual rate ratios ranged from 28.06%-793.16% of the benchmark.

PT/OT Key Considerations

<u>Stakeholder Feedback</u>

- The Physical Therapy Association of Colorado has been trying to get a rate increase directly through the JBC for several years.
- Providers are unwilling to accept Medicaid patients because the rates are too low.
- The increase usage of telemedicine visits during the pandemic has had a positive impact on PT/OT.

PT/OT Key Considerations

Additional Considerations

- Data shows utilization, rendering providers, and expenditures are increasing for PT/OT services, suggesting PT/OT providers are willing to accept Medicaid patients.
- Most visits for therapy services include provision of more than one service.

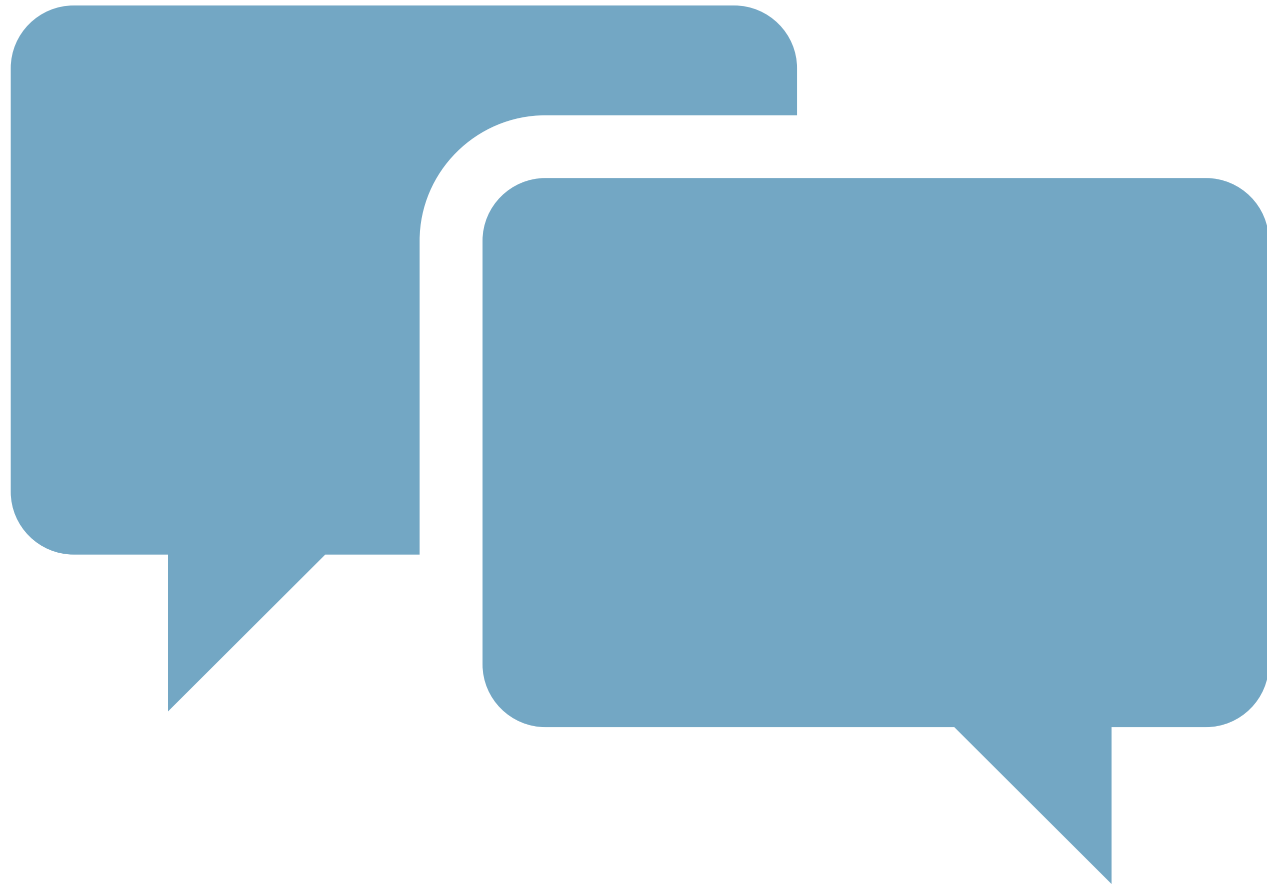
PT/OT Working Recommendations

The Department recommends:

- a rebalancing of PT/OT rates and will evaluate individual services that were identified to be below 80% of the benchmark and above
  100% of the benchmark to identify services that would benefit from an immediate rate change.

Questions?

Stakeholder Comments



Committee Discussion

Prosthetics, Orthotics, and Supplies (POS)

- Analyses suggest that POS payments at 80.80% of the benchmark
were sufficient to allow for member access and provider retention.

- Individual rate ratios ranged from 4.46%-1,233.91% of the benchmark.

POS Key Considerations

Stakeholder Feedback

- Several supplies, especially those for pediatric patients, are not covered by Medicare, due to the difference in populations served by Medicare.
- Providers request an increase to at least 80% of Medicare rates, and 90% would be preferred.

POS Key Considerations

Additional Considerations

- Medicare was the primary payor used for the rate comparison analysis; where a Medicare comparison was unavailable, the rate was compared with other states' Medicaid rates.
  - Medicare rates for supplies are comparable due to the nature of the benefit.
  - The rates compared to other states' Medicaid rates provide insight to how we compare on reimbursement for supplies that are not covered by Medicare.
- Data analyses did not include out-of-state claims including those from border towns and mail-order utilization.

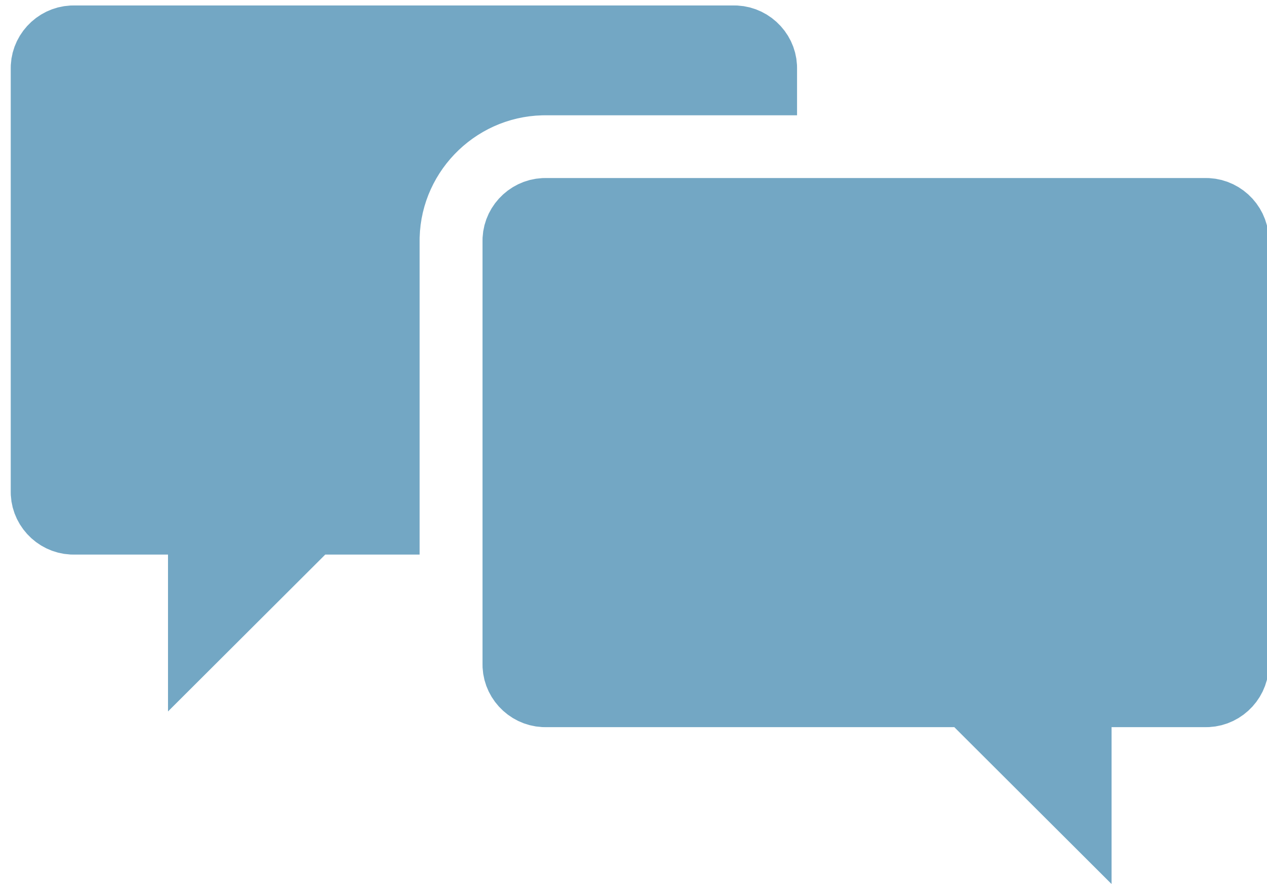
POS Working Recommendations

The Department recommends:

- rebalancing POS rates and will evaluate individual services that were identified to be below 80% of the benchmark and above
  100% of the benchmark to identify services that would benefit from an immediate rate change.

Questions?

Stakeholder Comments



Committee Discussion

Vision

- Analyses suggest that vision payments at 81.13% of the benchmark were sufficient to allow for member access and provider retention.

- Individual rate ratios ranged from 25.06%-190.56% of the benchmark.

Vision Key Considerations

Stakeholder Feedback

- There was a large increase in provider enrollment for vision services following a rate increase five years ago; for this reason, a decrease in rates could have a negative impact on provider retention.

Vision Key Considerations

Additional Considerations

- The Department did not have any feedback regarding vision services or rates.

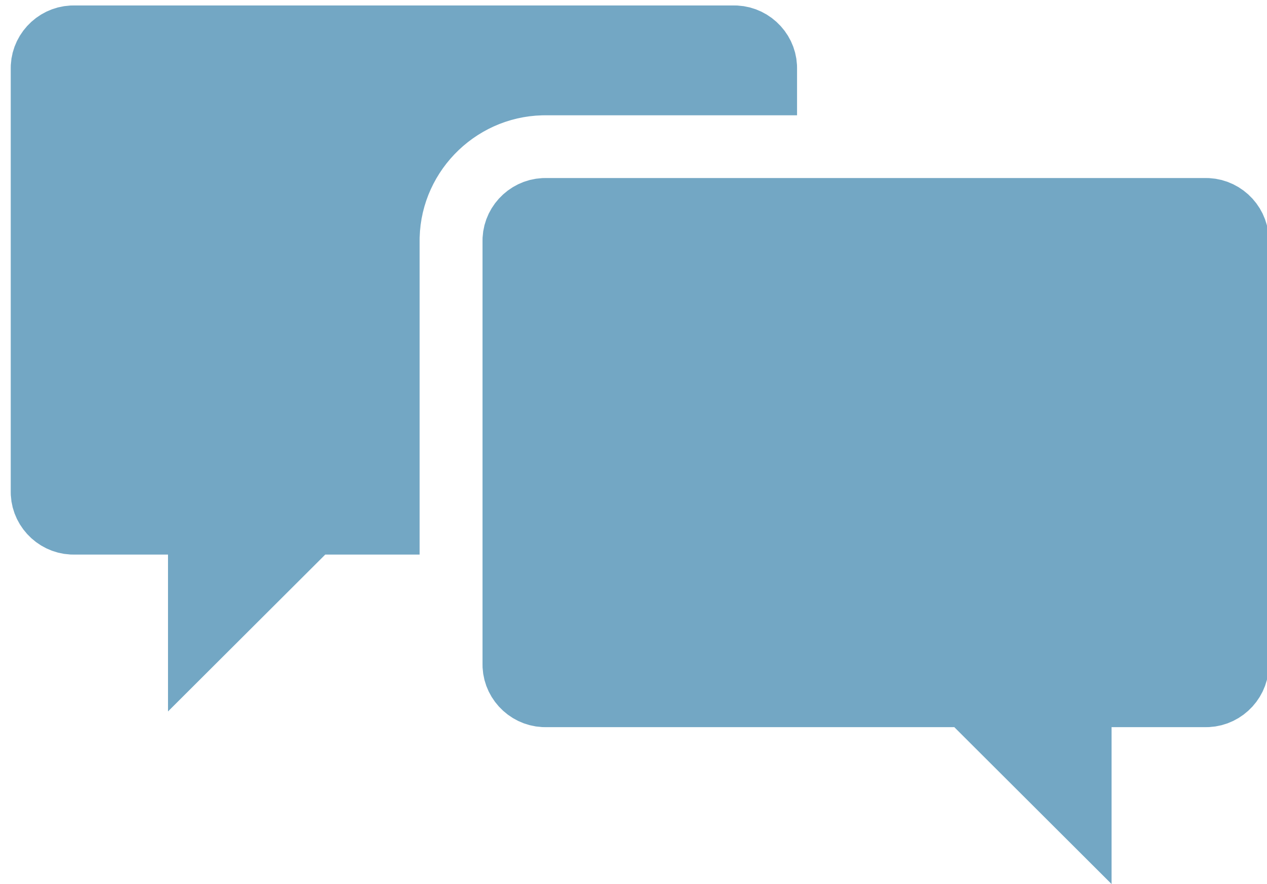
Vision Working Recommendations

The Department recommends:

- rebalancing vision rates and will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

Questions?

Stakeholder Comments



Committee Discussion

Announcements & Next Steps

- Next Meeting – November 20, 2020, 9:00 a.m.-12:00 p.m.
- Next Steps:
  - 2020 Medicaid Provider Rate Review Recommendation Report is due November 1, 2020
  - Data analyses are under way for 2021 Medicaid Provider Rate Review Analysis Report. Services under review: Targeted Case Management (TCM), Emergency Medical Transportation (EMT), Non-Emergent Medical Transportation (NEMT), and Home and Community-Based Services (HCBS) Waivers
- 2020-2021 Meeting Schedule:
  - February 5, 2021, 9:00 a.m.-2:00 p.m.
  - June 18, 2021, 9:00 a.m.-12:00 p.m.
  - August 27, 2021, 9:00 a.m.-12:00 p.m.
  - November 5, 2021, 9:00 a.m.-12:00 p.m.
- If you have additional comments that are not within the scope of this meeting, they can be sent to HCPF_RateReview@state.co.us

Eloiss Hulsbrink
Rate Review Stakeholder Relations Specialist
Eloiss.Hulsbrink@state.co.us

HCPF_RateReview@state.co.us

Thank You!