COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

June 15, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Joint Budget Committee on the Medicaid Provider Rate Review Recommendation Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to "conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review … compare the rates paid with available benchmarks … and use qualitative tools to assess whether payments are sufficient … on or before May 1st ."

The Department's report contains appropriate analyses, rate comparisons, and sufficiency assessments for seven sets of services: Transportation (Emergency and Non-Emergent Medical Transportation (EMT/NEMT); Home and Community-Based Services (HCBS) Waivers; and Targeted Case Management (TCM). We apologize for the delay in submitting this report.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin at jo.donlin@state.co.us.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2021 Medicaid Provider Rate Review Analysis Report

Cc: Representative Julie McCluskie, Vice-chair, Joint Budget Committee

Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
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Bonnie Silva, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

June 15, 2021

Timothy Dienst, Chair
Medicaid Provider Rate Review Advisory Committee
303 East 17th Avenue
Denver, Colorado 80203

Dear Mr. Dienst:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Medicaid Provider Rate Review Advisory Committee on the Medicaid Provider Rate Review Analysis Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review … compare the rates paid with available benchmarks … and use qualitative tools to assess whether payments are sufficient … on or before May 1, 2016.

The Department's report contains appropriate analyses, rate comparisons, and sufficiency assessments for three sets of services: Transportation (Emergency and Non-Emergent Medical Transportation (EMT/NEMT); Home and Community-Based Services (HCBS) Waivers, and Targeted Case Management (TCM). We apologize for the delay in submitting this comprehensive report.

If you require further information or have additional questions, please contact me at Kim.Bimestefer@state.co.us, our Medicaid Director Tracy Johnson at Tracy.Johnson@state.co.us, or the Department's Rate Review Team at HCPF_RateReview@state.co.us.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2021 Medicaid Provider Rate Review Annual Analysis Report

Cc: Dixie Melton, Vice Chair, Medicaid Provider Rate Review Advisory Committee
Melissa Benjamin, Medicaid Provider Rate Review Advisory Committee
David Friedenson, Medicaid Provider Rate Review Advisory Committee
Rob Hernandez, Medicaid Provider Rate Review Advisory Committee
Vennita Jenkins, Medicaid Provider Rate Review Advisory Committee
Kimberly Kretsch, Medicaid Provider Rate Review Advisory Committee
David Lamb, Medicaid Provider Rate Review Advisory Committee
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

2021 Medicaid Provider Rate Review Analysis Report

May 21, 2021

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

COLORADO
Department of Health Care Policy & Financing

Contents

Executive Summary **7**

Introduction **10**

Payment Philosophy 10

HCBS Waiver Background 11

HCBS Waiver Rate Setting Methodology 12

HCBS Rate Comparison State Selection 12

Format of Report **14**

Service Description 14

Rate Comparison Analysis 14

Access to Care Analysis 15

Stakeholder Feedback 16

Additional Considerations 16

Additional Research 16

Conclusion 17

Limitations **19**

Emergency Medical Transportation (EMT) **20**

Service Description 20

Rate Comparison Analysis 20

Access to Care Analysis 21

Utilizers per Provider (Panel Size) Summary 21

Utilizer Density 22

Penetration Rate 23

Member-to-Provider Ratios 24

Drive Times 25

Stakeholder Feedback 26

Additional Considerations 26

Additional Research 27

Conclusion 27

Non-Emergent Medical Transportation (NEMT) **28**

Service Description 28

Rate Comparison Analysis 28

Access to Care Analysis 29

Utilizers per Provider (Panel Size) Summary 29

Utilizer Density 30

Penetration Rate 31

COLORADO
Department of Health Care Policy & Financing

Member-to-Provider Ratios....32
Drive Times....33
Stakeholder Feedback....34
Additional Considerations....34
Additional Research....34
Conclusion....35
Waiver for Persons with Brain Injury (BI)....36
Service Description....36
Rate Comparison Analysis....36
Access to Care Analysis....38
Utilizers per Provider (Panel Size) Summary....38
Utilizer Density....39
Penetration Rate....40
Member-to-Provider Ratios....41
Drive Times....42
Stakeholder Feedback....43
Additional Considerations....43
Additional Research....44
Conclusion....44
Waiver for Persons with Developmental Disabilities (DD)....45
Service Description....45
Rate Comparison Analysis....45
Access to Care Analysis....47
Utilizers per Provider (Panel Size) Summary....47
Utilizer Density....48
Penetration Rate....49
Member-to-Provider Ratios....50
Drive Times....51
Stakeholder Feedback....52
Additional Considerations....52
Additional Research....52
Conclusion....52
Supported Living Services Waiver (SLS)....54
Service Description....54
Rate Comparison Analysis....54
Access to Care Analysis....56
Utilizers per Provider (Panel Size) Summary....56
Utilizer Density....57
Penetration Rate....58

Member-to-Provider Ratios....59
Drive Times....60
Stakeholder Feedback....61
Additional Considerations....61
Additional Research....61
Conclusion....61
Community Mental Health Supports Waiver (CMHS)....62
Service Description....62
Rate Comparison Analysis....62
Access to Care Analysis....64
Utilizers per Provider (Panel Size) Summary....64
Utilizer Density....65
Penetration Rate....66
Member-to-Provider Ratios....67
Drive Times....68
Stakeholder Feedback....69
Additional Considerations....69
Additional Research....70
Conclusion....70
Elderly, Blind, and Disabled Waiver (EBD)....71
Service Description....71
Rate Comparison Analysis....71
Access to Care Analysis....73
Utilizers per Provider (Panel Size) Summary....73
Utilizer Density....74
Penetration Rate....75
Member-to-Provider Ratios....76
Drive Times....77
Stakeholder Feedback....78
Additional Considerations....78
Additional Research....79
Conclusion....79
Waiver for Persons with Spinal Cord Injury (SCI)....80
Service Description....80
Rate Comparison Analysis....80
Access to Care Analysis....82
Utilizers per Provider (Panel Size) Summary....82
Utilizer Density....83
Penetration Rate....84

Member-to-Provider Ratios....85
Drive Times....86
Stakeholder Feedback....87
Additional Considerations....87
Additional Research....88
Conclusion....88
Waiver for Children with Life Limiting Illness (CLLI)....89
Service Description....89
Rate Comparison Analysis....89
Access to Care Analysis....91
Utilizers per Provider (Panel Size) Summary....91
Utilizer Density....92
Penetration Rate....93
Member-to-Provider Ratios....94
Drive Times....95
Stakeholder Feedback....96
Additional Considerations....96
Additional Research....96
Conclusion....96
Children's Extensive Supports Waiver (CES)....98
Service Description....98
Rate Comparison Analysis....98
Access to Care Analysis....100
Utilizers per Provider (Panel Size) Summary....100
Utilizer Density....101
Penetration Rate....102
Member-to-Provider Ratios....103
Drive Times....104
Stakeholder Feedback....105
Additional Considerations....105
Additional Research....105
Conclusion....105
Children's Habilitative Residential Waiver (CHRP)....106
Service Description....106
Rate Comparison Analysis....106
Access to Care Analysis....108
Utilizers per Provider (Panel Size) Summary....108
Utilizer Density....109
Penetration Rate....109

Member-to-Provider Ratios....109
Drive Times....110
Stakeholder Feedback....111
Additional Considerations....111
Additional Research....111
Conclusion....111
Children's Home and Community Based Waivers (CHCBS)....112
Service Description....112
Rate Comparison Analysis....112
Access to Care Analysis....114
Utilizers per Provider (Panel Size) Summary....114
Utilizer Density....115
Penetration Rate....116
Member-to-Provider Ratios....117
Drive Times....118
Stakeholder Feedback....119
Additional Considerations....119
Additional Research....119
Conclusion....119
Home and Community-based Services (HCBS) Waivers in Aggregate....120
Service Description....120
Rate Comparison Analysis....120
Adult Day Services....121
Alternative Care Facility (ACF)....123
Care Coordination....125
Case Management....127
Community Connector....129
Community Transitions....131
Day Habilitation Services....133
Foster Home....135
Group Home....137
Home Delivered Meals Services....139
Homemaker Services....141
In-Home Support Services (IHSS) Health Maintenance Activities....143
IHSS Homemaker Services....145
IHSS Personal Care Services....147
Life Skills Training & Independent Living Skills Training (ILST)....149
Non-Medical Transportation (NMT)....151
Pain & Symptom Management....153
Personal Care Services....155
Prevocational Services....157
Professional Therapy Services....159
Residential Habilitation Services....162

Respite Services 164
Supported Employment Services 166
Therapy – Behavioral Services....168
Transitional Living Program (TLP) Services 170
Targeted Case Management (TCM) 171
Service Description....171
Modified Rate Comparison Analysis....171
Access to Care Analysis 173
Utilizers per Provider (Panel Size) Summary....173
Utilizer Density 174
Penetration Rate 175
Member-to-Provider Ratios....176
Drive Times....177
Stakeholder Feedback....178
Additional Considerations 178
Additional Research 178
Conclusion....178
Appendices 179
Appendix A – Glossary 179
Appendix B – Transportation Services Data Analysis Methodology....179
Appendix C – HCBS Waiver and TCM Data Analysis Methodology 179
Appendix D – CDASS Rate Analysis 179
Appendix E – Service Grouping Data Books....179
Appendix F – HCBS Service Groupings by Waiver 179
Appendix G – Rate Comparison with PACE and HCBS Services....179
Appendix H – OCL Stance on Direct Care Workforce 179
Appendix I – COVID-19 Impact on Services....179
Appendix J – Transportation Services Visual Data....179

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 One of the second five-year rate review cycle, are listed in the table below.

Rate Review – Year One Services, Cycle Two	
Emergency Medical Transportation (EMT)	Waiver for Persons with Spinal Cord Injury (SCI)
Non-Emergent Medical Transportation (NEMT)	Waiver for Children with Life Limiting Illnesses (CLLI)
Waiver for Persons with Brain Injury (BI)	Children's Extensive Support Waiver (CES)
Waiver for Persons with Developmental Disabilities (DD)	Children's Habilitative Residential Program (CHRP)
Supported Living Services Waiver (SLS)	Children's Home and Community-based Services Waiver (CHCBS)
Community Mental Health Supports Waiver (CMHS)	Home and Community-based Services (HCBS) Waivers in Aggregate
Elderly, Blind, and Disabled Waiver (EBD)	Targeted Case Management (TCM)

The Rate Review Process is an evidence-based process informed by rate comparisons and access data, Department subject matter experts, as well as stakeholder and Medicaid Provider Rate Review Advisory Committee (the committee) feedback. This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder and committee feedback, additional considerations and research, and Department conclusions for each service.

The Department will evaluate findings and generate recommendations using this report and through collaboration in Medicaid Provider Rate Review public meetings. The recommendations will be presented in the Department's 2021 Medicaid Provider Rate Review Recommendation Report on November 1, 2021.

For each service grouping, rate benchmark comparisons are listed below. These comparisons describe, as a percentage, how Colorado Medicaid[1] payments compare to other payers.

- Emergency Medical Transportation (EMT): **40.92%**
- Non-Emergent Medical Transportation (NEMT): **37.51%**
- Home and Community-Based Services (HCBS) Waivers: **97.72%**
    - Waiver for Persons with Brain Injury (BI): **116.80%**
    - Waiver for Persons with Developmental Disabilities (DD): **103.81%**
    - Supported Living Services Waiver (SLS): **85.00%**
    - Community Mental Health Supports Waiver (CMHS): **80.42%**
    - Elderly, Blind, and Disabled Waiver (EBD): **95.22%**

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

    - Waiver for Persons with Spinal Cord Injury (SCI): **88.62%**
    - Waiver for Children with Life Limiting Illnesses (CLLI): **106.17%**
    - Children's Extensive Support Services (CES): **131.11%**
    - Children's Habilitative Residential Program (CHRP): **129.38%**
    - Children's Home and Community-based Services Waiver (CHCBS): **87.71%**
- Targeted Case Management (TCM): **87.84%**

The Departments conclusions for each service grouping are summarized below.

- Analyses suggest that EMT rates at 40.92% of the benchmark were sufficient for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[2]
- Analyses suggest that NEMT rates at 37.51% of the benchmark were sufficient for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[3]
- Analyses suggest BI rates at 116.80% of the benchmark were sufficient for member access and provider retention.
- Analyses suggest DD rates at 103.81% of the benchmark were sufficient for member access and provider retention.
- Analyses suggest SLS rates at 85.00% of the benchmark were sufficient for member access and provider retention.
- Analyses were inconclusive to determine if CMHS rates at 80.42% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[4]
- Analyses were inconclusive to determine if EBD rates at 95.22% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[5]
- Analyses suggest SCI rates at 88.62% of the benchmark were sufficient for member access and provider retention.
- Analyses were inconclusive to determine if CLLI rates at 106.17% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[6]
- Analyses suggest CES rates at 131.11% of the benchmark were sufficient for member access and provider retention.
- Analyses suggest CHRP rates at 129.38% of the benchmark were sufficient for member access and provider retention.

[2] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.
[3] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.
[4] The Department is conducting additional research and will identify opportunities to improve access to care and provider retention.
[5] The Department is conducting additional research and will identify opportunities to improve access to care and provider retention.
[6] The Department is conducting additional research and will identify opportunities to improve access to care and provider retention.

- Analyses suggest CHCBS rates at 87.71% of the benchmark were sufficient for member access and provider retention.
- Analyses suggest TCM rates at 87.84% of the benchmark were sufficient for member access and provider retention.

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.[7]

Services reviewed this year encompass a subset of all services reviewed over the five-year rate review cycle.

Stakeholders are invited to attend Medicaid Provider Rate Review public meetings, engage in the Rate Review Process and provide input on access, quality, and provider rates.. The five-year rate review schedule, Department reports, the Medicaid Provider Rate Review public meeting schedule, public meeting materials, and more can be found on the Department website.

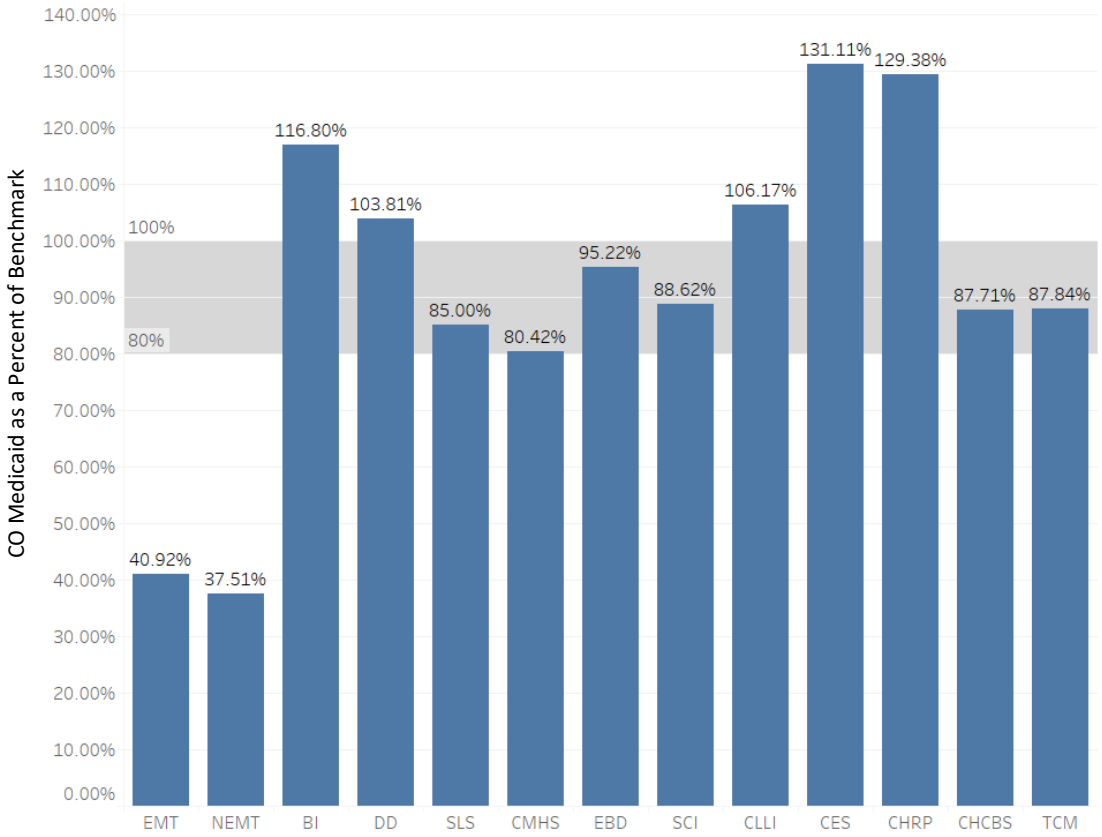

Figure 1. Colorado Medicaid rate benchmark comparison for all Year One (Cycle 2) service groupings in CY 2019.

[7] The Department shares plans for further investigation to determine whether or not rates are sufficient for member access and provider retention within the "Additional Research" section of each service grouping throughout the report. In addition, a summary of how each conclusion was reached is contained in the "Conclusion" section of each service grouping throughout the report.

Introduction

The Colorado Department of Health Care Policy & Financing (the Department) administers the State's public health insurance programs, including Health First Colorado (Colorado's Medicaid Program), Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify.[8] Colorado Medicaid is jointly funded by a federal-state partnership. Our mission is to improve health care equity, access, and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

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 reports published by the Department, and assist the Department in conducting public meetings to allow stakeholders the opportunity to participate in the process.

Medicaid Provider Rate Review public meetings for services under review this year, Year One of the second five-year rate review cycle (Year One, Cycle Two), began in November 2020 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:

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

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., HCBS Waiver Services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g. pediatric services).
3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar (e.g., home health services).
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 payment 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.

HCBS Waiver Background

HCBS Waivers allow state Medicaid agencies to waive certain Medicaid program requirements.[9] HCBS Waivers allow states to:

- waive certain income and/or eligibility criteria for people living with disabilities;
- provide specific services to target groups and geographic regions of the state; and
- allow members to receive services in their home and communities to prevent institutionalization.

HCBS Waivers must:

- Demonstrate cost effectiveness, that is, that the costs of providing services in the community are expected to be lower than, or equal to, providing them in an institutional setting. Examples of institutional settings include nursing homes, hospitals, intermediate care facilities for individuals with intellection disabilities and long-term psychiatric facilities.
- Set adequate and reasonable provider standards that meet the needs of the target population.
- Ensure that services follow an individualized and person-centered plan of care.

[9] Home- and Community-Based Services (HCBS) are offered through states' Medicaid programs upon waiver authorization. There are five waiver authorization options available to states. Colorado has 1915(c) authority for its HCBS waivers; more information is available on the Center for Medicare and Medicaid Services (CMS) website.

- Ensure the protection of members' health and welfare.

The State of Colorado operates 10 waiver programs to meet the needs of different populations. HCBS waivers provide different services, different levels of service, and different definitions for like services.[10] Each waiver offers a unique set of waiver services to align with the needs of the members enrolled in each waiver, and members sometimes move from one waiver to another to receive the support they need. The number and type of services vary by waiver and each waiver is renewed every five years.

HCBS Waiver Rate Setting Methodology

Most HCBS waiver services in Colorado are paid using a fee-for-services (FFS) reimbursement methodology. Beginning in 2011, Colorado adopted an FFS rate setting methodology for HCBS Waivers that incorporates the following inputs:

- Salary expectations, including direct and indirect care hours, and full-time equivalency of each position providing the service;
- Facility expectations, including rental, maintenance, utilities, phone, and internet costs;
- Administrative expectations, including software upgrades and office supplies; and
- Capital expectations, which, though not typically covered by Medicaid for HCBS Waiver services, may include, but is not limited to, supplies for art and play therapy, or massage tables for massage therapy.

HCBS Waiver service rates set through this process are then evaluated for alignment with other payers in the market.

HCBS rates are subject to periodic adjustments based on legislative appropriations; such appropriations may reduce or increase the Department-calculated rate. Beginning in 2016, the Department initiated a process of re-setting rates as HCBS Waivers are renewed with the Center for Medicare and Medicaid Services (CMS). Doing so allows the Department to examine and document waiver service rates in detail. While a significant number of rates have been recently reviewed for the various inputs mentioned above, some rates have, historically, only been adjusted for changes in legislative appropriations.

HCBS Rate Comparison State Selection

Medicare does not cover most of the waiver services outlined in this report. Since HCBS Waiver services are typically unique to Medicaid, the Department relied on other state Medicaid agencies' HCBS Waivers for rate benchmark comparisons. The Department examined Medicaid programs in other states to identify HCBS Waivers with multiple comparable services.[11] The following criteria guided the Department's selection of comparator states:

[10] Under Medicaid, states are required to cover mandatory benefits and may choose to cover optional benefits. All waivers are optional benefits. For a more complete list of mandatory and optional benefits, see the Medicaid and CHIP Payment and Access Commission (MACPAC) benefits page.

[11] In November 2015, the Department responded to a Legislative Request for Information (LRFI) asking the Department to compare Colorado Medicaid reimbursement rates to the rates of other payers. The LRFI contained rate comparison information for multiple services, including HCBS which relied upon rate information from the Medicaid programs of

- The state was used in the 2017 Medicaid Provider Rate Review Analysis Report to compare HCBS service rates;
- The state had FFS, as opposed to managed care, delivery systems for HCBS Waiver services;
- HCBS Waivers were approved under 1915(c) waiver authority;
- HCBS Waivers covered similar services and target populations;
- There were comparable numbers of enrollees; and
- The state had similar geography or population density.

More information on states included for the comparison in this analysis, including assumptions made to complete the data analysis, in contained in Appendix C.

Arizona, California, Washington, D.C., Illinois, and Ohio. Further research into these states led to state selection criteria and the states used in the 2017 Medicaid Provider Rate Review HCBS Waiver Analysis Report; the Department included states used in the 2017 analysis and added additional states using the same criteria, where appropriate, to supplement data validity.

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 time frame they represent are:

- Total Adjusted Expenditures – CY 2019[12]
- Total Members Utilizing Services – CY 2019
- Year-over-year Change in Members Utilizing Services – CY 2018 and CY 2019[13]
- Total Active Providers[14] – CY 2019
- Year-over-year Change in Active Providers – CY 2018 and CY 2019[15]

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. 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 CY 2019 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 individual rate ratios.[16]

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. 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's rates are typically updated on a periodic basis; and
- most services covered by Colorado Medicaid are also covered by the Medicare program.

[12] 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 (Transportation services) and Appendix C (HCBS Waivers and TCM).
[13] For all services, year-over-year change in members was calculated using data from CY 2018 and CY 2019.
[14] An active provider is any provider with at least one Colorado Medicaid paid claim in a given month between January 2019 -December 2019.
[15] For all services, year-over-year change in providers was calculated using data from CY 2018 and CY 2019.
[16] Definitions for certain terms in this report, such as rate ratio and rate benchmark comparison, are contained in Appendix A.

Technical information for transportation services is contained in Appendix B; technical information for HCBS Waivers and waiver services is contained in Appendix C.

Access to Care Analysis

The Department contracted with the actuarial firm, Optumas, to assist in evaluating access. 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.[17]

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., utilizer density), 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 indicate how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurance, or to the uninsured population.[18]

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 of the service.
- Utilizer density – the total number of distinct utilizers of the service in each county.
- Penetration rate – the estimated share of total Colorado Medicaid members in a geographic area (county) that received the service, calculated per 1,000 members. Comparing the penetration rate across counties helps identify atypical utilization.[19]
- Member-to-provider ratio – the total number of Colorado Medicaid members residing in a geographic area compared to the total number of active providers of the service in the geographic area; calculated as providers per 1,000 members.[20] For HCBS waivers, the number of total members was restricted to Health First Colorado members that are the ages served under each particular waiver; this is to provide consistency across services and to improve accuracy of this metric, since waiver services are only available to certain age groups. Each age group is noted within the member-to-provider section.
- Drive times – the percentage of total Colorado Medicaid members that live within certain distances from service 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 total members residing within each time band listed below:
    - 0 to 30 minutes;

[17] 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. See Figure 2. Colorado Counties and RAE County Classifications for a breakdown of each county classification.
[18] See the Limitations section below for more information regarding this consideration.
[19] A higher penetration rate might indicate that there is a higher concentration of members in need of services relative to other counties; or may be affected by 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.
[20] This metric allows for comparison across areas with large differences in population size.

- 30 to 45 minutes
- 45 minutes to an hour;
- an hour or more.

Access to care metrics are based on CY 2019 administrative claims data.[21]

Access to care metrics are intended to be reviewed with consideration of all provided access data metrics and are not intended to denote that all Medicaid members are able to access a particular provider set (e.g., HCBS waiver service providers).[22] The purpose of including a range of potential and realized access to care metrics is to assess capacity of current enrolled providers based on members currently accessing the services and member who may potentially access the services based on eligibility criteria.

More technical information, including details regarding how to read and interpret access to care analysis results, is contained in Appendix B (Transportation services) and Appendix C (HCBS Waivers and TCM).

Stakeholder Feedback

This section contains summaries of stakeholder comments received during the Rate Review Process.[23]

Additional Considerations

This section contains summaries of other considerations that informed the Department's conclusions. Themes of additional considerations include, but are not limited to:

- Stakeholder feedback provided by subject matter experts at the Department;
- Service-specific data (e.g., primary utilizer populations, billing specificities, etc.);
- Benefit restrictions or limitations;
- Additional research that has already been conducted; and
- Clarifying data responding to stakeholder feedback.

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 Department's 2021 Medicaid Provider Rate Review Recommendation Report is developed. Options for additional research include:

- 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 conducted last year for the Department's Access Monitoring Review Plan.

[21] The utilizers per provider (panel size) metric is based on monthly administrative claims data from March 2017-December 2019 for all services, except for HCBS waivers, which are based on claims data from July 2017-December 2019.
[22] 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.
[23] With permission from stakeholders, the Department posts public comments on the Department website, except comments containing PHI. This report references written comments the Department received September 2020-April 2021. The Department will post additional written comment on the Department website as it is received. Stakeholders did not provide comments for all service groupings; therefore, some service grouping sections do not summarize stakeholder comments.

- 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.

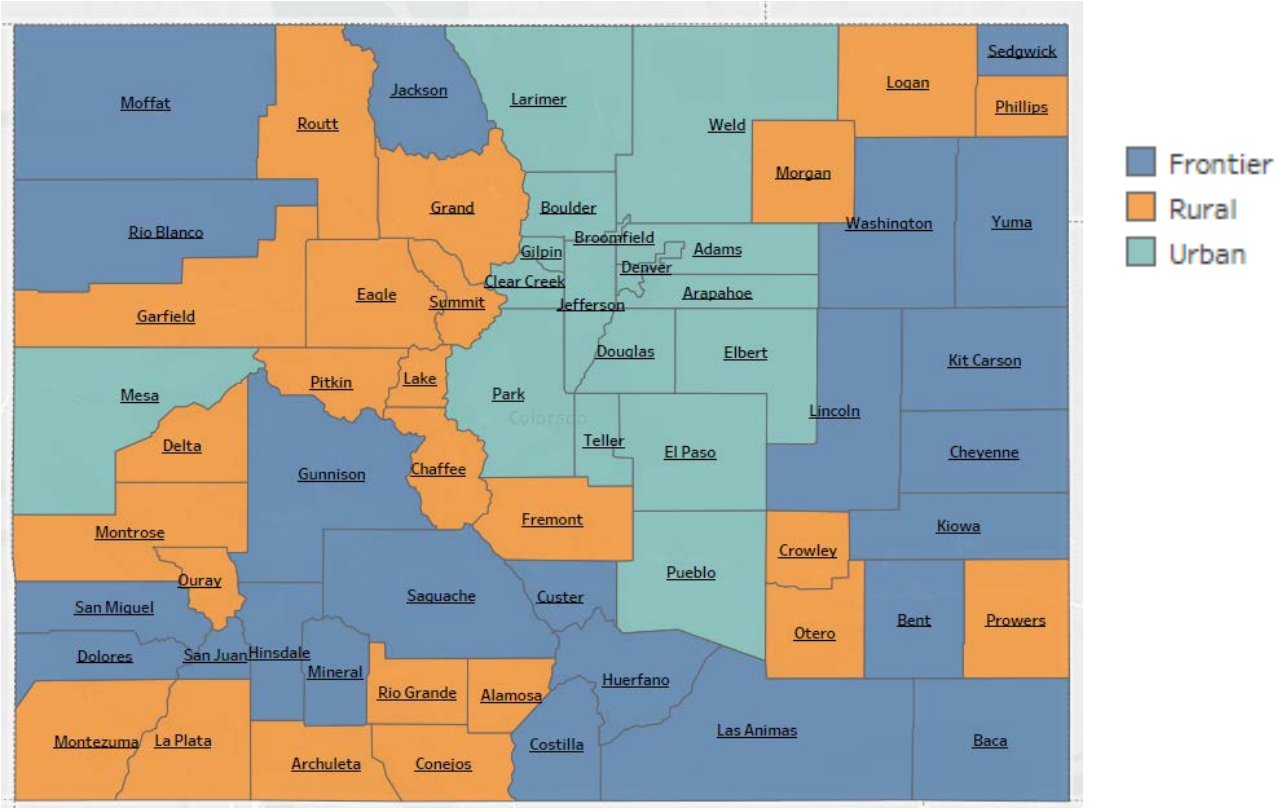

Figure 2. Colorado counties by RAE county classification.

RAE County Classification[24]					
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.

[24] 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 than 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.[25] 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 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 changes to the access analysis methodology utilized in the 2020 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.

[25] 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 https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1010.

Emergency Medical Transportation (EMT)

Service Description

The Emergency Medical Transportation (EMT) service grouping is comprised of 10 procedure codes. EMT services provide emergency transportation to a facility and is available to all Colorado Medicaid members. EMT services were previously reviewed in the 2016 Medicaid Provider Rate Review Analysis Report.

EMT Statistics	
Total Adjusted Expenditures CY 2019	$27,486,917
Total Members Utilizing Services in CY 2019	64,808
CY 2019 Over FY 2018 Change in Members Utilizing Services	(2.70%)
Total Active Providers CY 2019	499
CY 2019 Over CY 2018 Change in Active Providers	(10.25%)

Table 2. EMT expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for EMT services are estimated at 40.92% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[26]

EMT Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$27,486,917	$67,171,134	**40.92%**

Table 3. Comparison of Colorado Medicaid EMT service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $39,684,217 in total funds if Colorado had reimbursed at 100% of the benchmark in CY 2019. Of the 10 procedure codes analyzed in this service grouping, nine were compared to Medicare, and one was compared to an average of six other states' Medicaid rates.[27] Individual rate ratios for EMT services were 29.44%-99.51%.

[26] Detailed information regarding the rate comparison analysis methodology is contained in Appendix B.
[27] States used in the EMT rate comparison analysis were Alabama, Arkansas, California, Montana, Oklahoma, and Wisconsin. For more details on EMT rate comparisons, see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for EMT services increased by 8.68% from an average of 20.41 utilizers per provider in CY 2018 to 22.19 utilizers per provider in CY 2019.[28] Additionally:

- In urban counties, average panel size increased from 35.57 in CY 2018 to 41.93 in CY 2019.
- In rural counties, average panel size increased from 5.44 in CY 2018 to 5.90 in CY 2019.
- In frontier counties, average panel size decreased from 2.61 in CY 2018 to 2.60 in CY 2019.

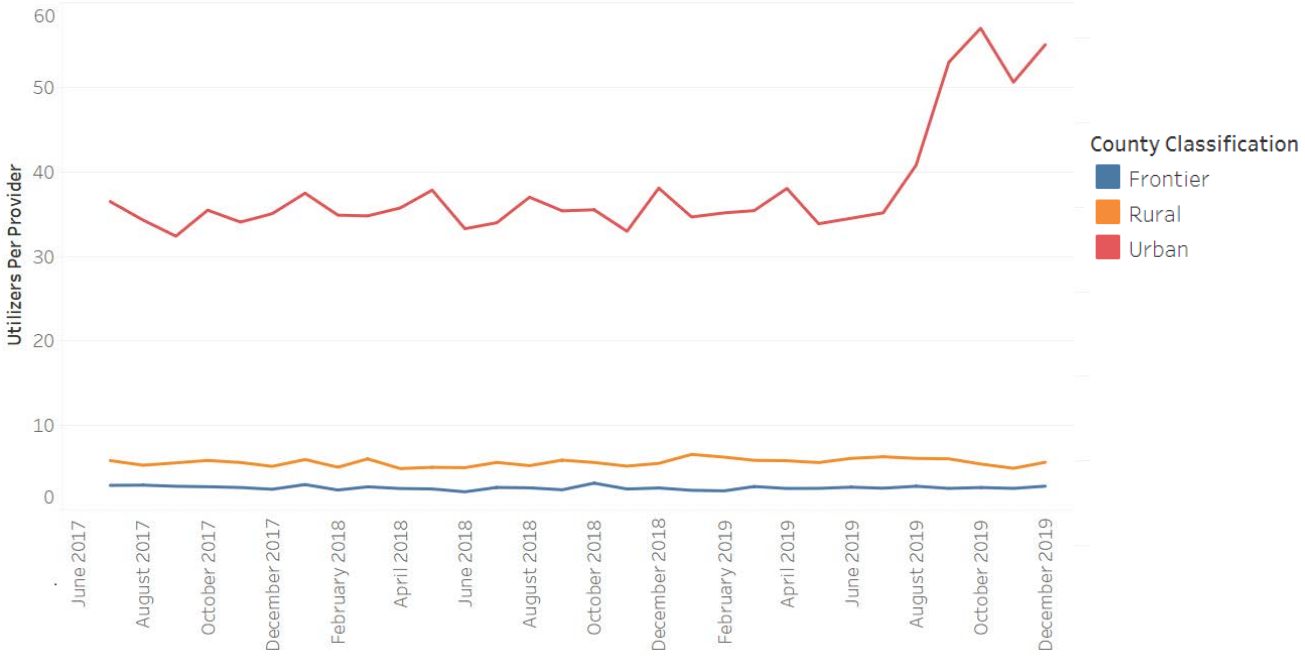

Figure 3. Utilizers per provider (panel size) for EMT services between July2017 and December 2019.

Analysis indicates that both the number of distinct utilizers and active providers remained relatively stable over this time across all county classifications. Additionally, there was a decrease in active providers from August 2019 to October 2019 in urban counties.

The number of distinct utilizers and total active providers observed in all counties remained relatively steady, which led to consistent number of utilizers per provider from June 2017 to August 2019.[29]

There was a noticeable change in urban counties from August 2019 to October 2019 that can be attributed to a perceived decrease in enrolled EMT providers, which was caused by a reconsolidation of provider IDs.[30] This was not permanent, and it did not impact the actual number of EMT providers rendering service to Medicaid members. Panel size remained relatively stable through December 2019 in rural and frontier counties.

[28] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[29] For data specific to distinct utilizers and active providers, see Appendix E.
[30] This included removing duplicate provider IDs, etc.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of EMT services reside throughout the state. Utilizer density for EMT services ranged from 36, in Phillips County, to 12,316 in Denver County, in CY 2019.

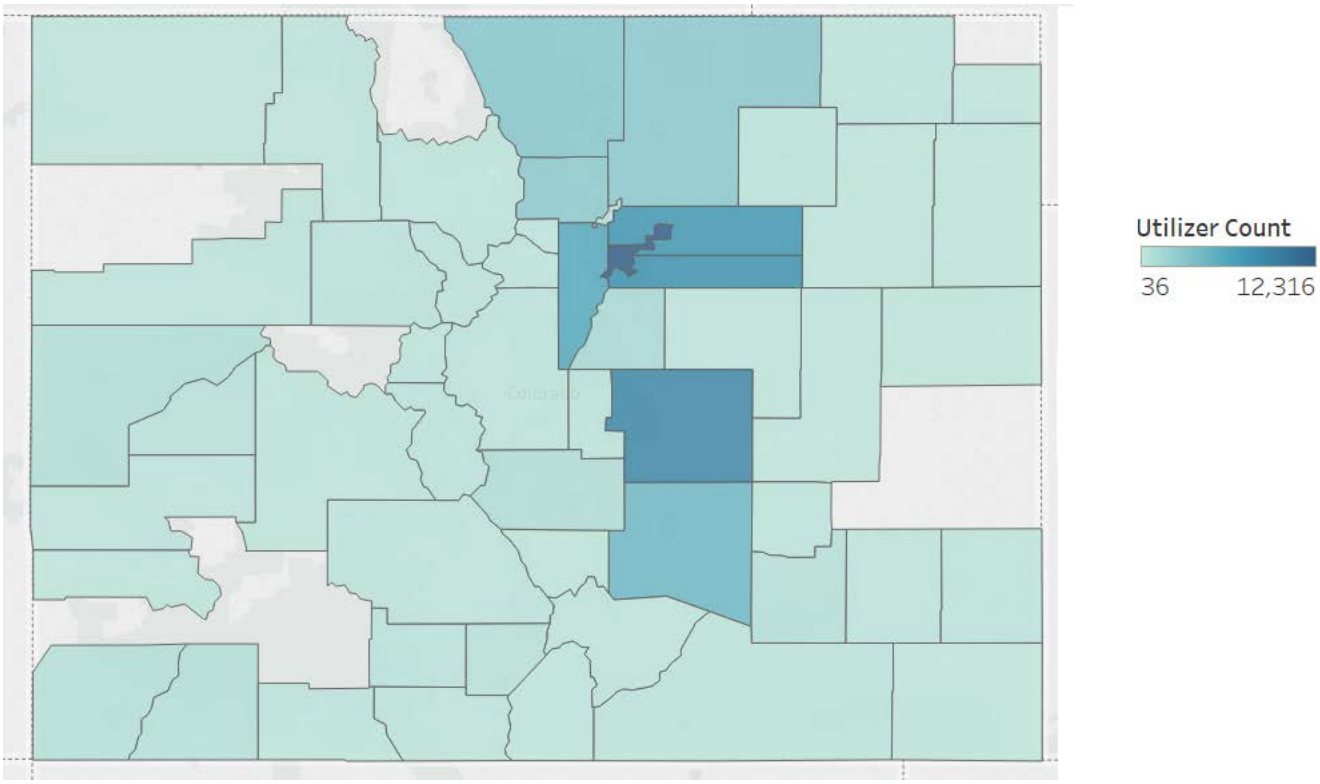

Figure 4. Utilizer density for EMT services by county for CY 2019.[31]

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

- relatively lower demand for EMT services, or a low number of Colorado Medicaid members utilizing EMT services.

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.

[31] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for EMT services ranged from 13.21 in Gunnison County, to 78.36 in Crowley County, in CY 2019.

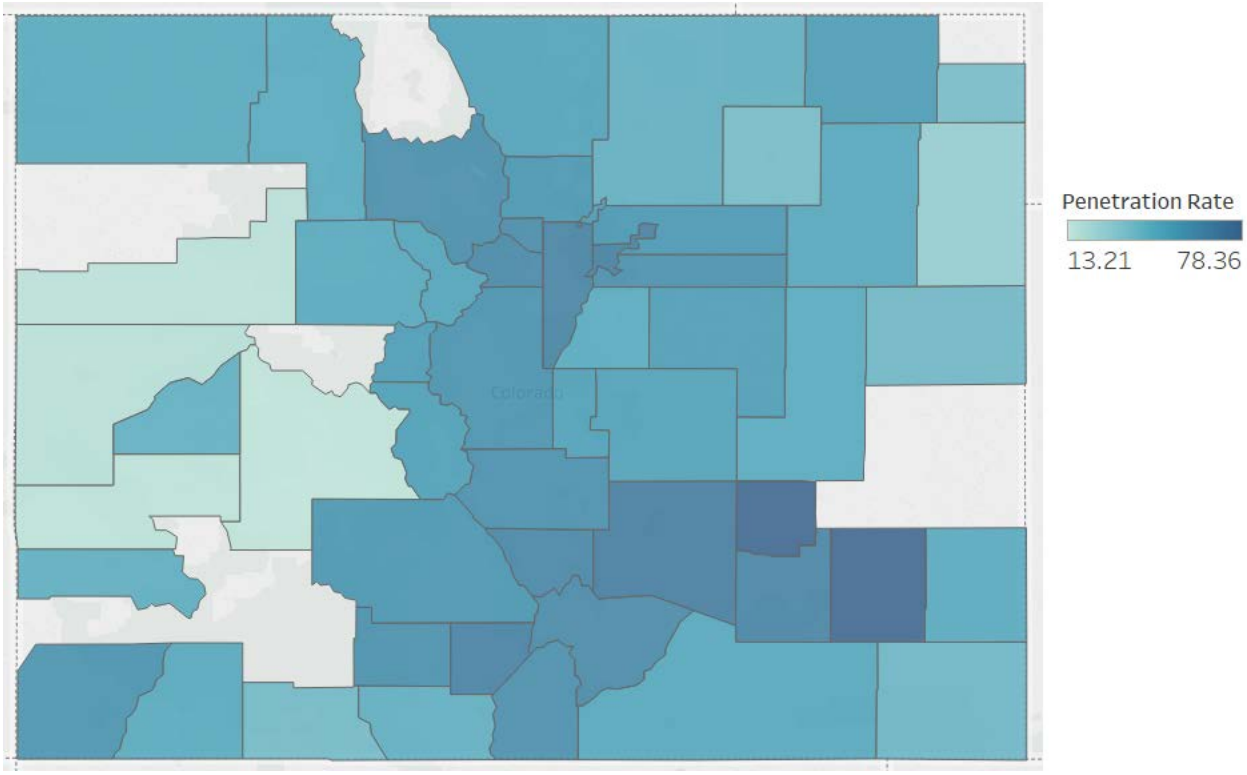

Figure 5. Penetration rates for EMT services by county in CY 2019.

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

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.

Member-to-Provider Ratios

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

EMT Member-to-Provider Ratios			
Region	**CY 2019 EMT Providers**	**CY 2019 Total Colorado Medicaid Members**	**Providers per 1,000 Members**
Frontier	171	48,210	3.55
Rural	246	179,929	1.37
Urban	422	1,357,110	0.31
Statewide	**499**	**1,478,090**	**0.34**

Table 5. Member-to-provider ratio for EMT services expressed as providers per 1,000 members by county classification in CY 2019.

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.[32]

[32] Currently, the Department does not use member-to-provider ratio standards specific to EMT 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 total Colorado Medicaid members that live within certain drive time bands from where EMT service providers are located.[33]

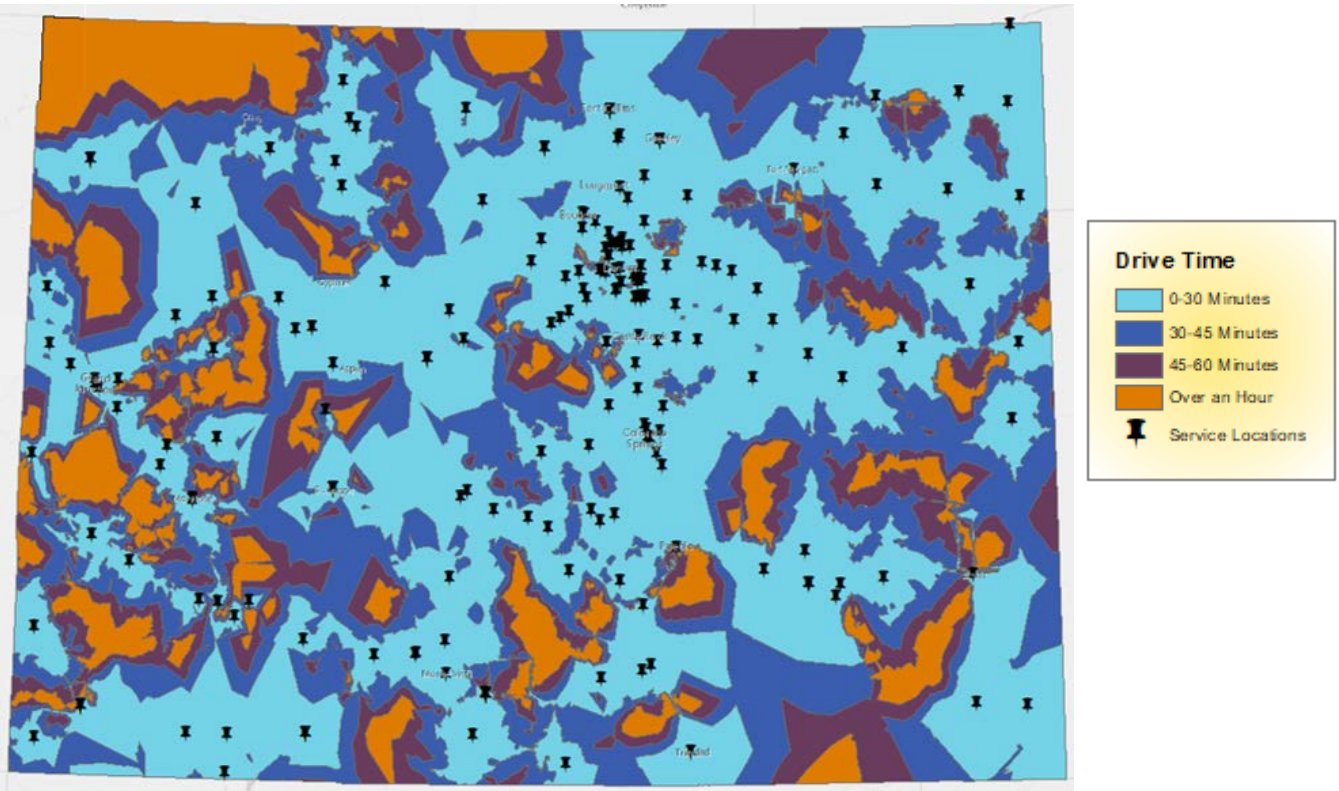

Figure 6. ArcGIS map of drive times of EMT provider service locations to members in CY 2019.

Overall, 95.36% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from an EMT provider. Additionally, 1.82% of total members resided approximately 30-45 minutes from an EMT provider; 1.49% of total members resided 45-60 minutes from an EMT provider. Finally, 1.33% of total members resided over an hour from an EMT provider.

Additionally, of the 95.36% of total Colorado Medicaid members in CY 2019 that resided 30 minutes or less from an EMT provider:[34]

- 73% of total members resided approximately 10 minutes or less from an EMT provider;
- 18% of total members resided approximately 10-20 minutes from an EMT provider;
- 7% of total members resided approximately 20-30 minutes from an EMT provider; and
- 2% of total members resided over 30 minutes from an EMT provider.

[33] Due to claims data, service locations shown on the ArcGIS map represent provider dispatch locations. Service locations represent dispatch location of providers that have submitted claims, not all auxiliary agencies or individual service delivery providers.

[34] The Department conducted drive times analyses at 10-minute bands for members residing 30 minutes or less from an EMT provider at the request of stakeholders.

Stakeholder Feedback

Themes of stakeholder feedback and committee member comments from the Medicaid Provider Rate Review Process public meeting on February 5, 2021,[35] as well as feedback received by Department staff regarding EMT services, are summarized below.

- EMT rate ratios are among the lowest for service groupings reviewed through the Medicaid Provider Rate Review Process.
- EMT services have a high readiness cost compared to other services due to the component of EMT services that require emergency vehicles to be staffed with trained service delivery providers and stocked with any medical equipment that may be required.
- There have been small incremental rate increases for particular EMT services, but not any noticeable, significant increases in reimbursement.
- Providers appreciate collaboration with Department on policies and the supplemental payment program since 2016 but indicate there are still gaps in reimbursement for EMT service providers.

Additional Considerations

Other considerations include:

- Since EMT services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report, both total members accessing EMT services and total active EMS providers increased. In addition, total expenditures increased by over $12 million;[36]
- As a result of the rate review team working with the Governor's Office in response to the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of EMT services, effective July 2017;[37]
- Effective January 1, 2018, the Department amended the Colorado State Plan to create an EMT Supplemental Payment program that allows eligible EMS providers to receive an annual supplemental payment for the uncompensated costs incurred by providing ground or air emergency medical transportation services to Medicaid beneficiaries. Data indicates the supplemental payment program provided 43 participating providers with $11 million in supplemental reimbursement in FY 2017-18, and provided 63 providers with $26 million in supplemental reimbursement;[38]
- The total number of active providers does not represent the total number of service delivery providers employed by agencies providing EMT services.

[35] The meeting recording for the Medicaid Provider Rate Review quarterly public meeting on February 21, 2020 can be found on the Rate Review Process Public Meetings web page.
[36] For more information, see the 2016 Medicaid Provider Rate Review Analysis Report.
[37] EMT services received a Targeted Rate Increase (TRI) of 6.61%, effective July 2018.
[38] For more information, see the Public Emergency Medical Services Supplemental Payment web page.

Additional Research

The Department plans to look at the utilization in counties that have a low penetration rate in both the 2016 and 2021 Medicaid Provider Rate Review Analysis Reports to identify if there is a persisting access to care issue or whether it is due to a lower need for Medicaid EMT services in those areas.[39]

Conclusion

Analyses suggest that EMT rates at 40.92% of the benchmark were sufficient for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[40]

The primary factors that led to this conclusion included:

- Increases were observed in total expenditures, distinct utilizers, and active providers since EMT services were previously reviewed in the 2016 Medicaid Provider Rate Review Analysis Report;
- Over 95% of members reside within 30 minutes of an EMT service location; and
- Low rates do not necessarily impact access to EMT services since EMT service providers cannot refuse services to members.

[39] Counties to review include Delta, Gunnison, Hinsdale, Ouray, Montrose, San Miguel, Garfield, Eagle, Pitkin, Summit, and Grand. Low penetration rates for EMT services could be due to a number of reasons that do not indicate an access issue, including, but not limited to, number and locations of urgent care facilities, access to and knowledge of nurse advice telephone lines, increased health literacy, longer general practice hours in those regions, or private payers covering more services in those regions.

[40] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.

Non-Emergent Medical Transportation (NEMT)

Service Description

The Non-Emergent Medical Transportation (NEMT) service grouping is comprised of 16 procedure codes. NEMT services provide transportation to and from Medicaid benefits and services and is available to all Medicaid members who receive full State Plan benefits. NEMT services were previously reviewed in the 2016 Medicaid Provider Rate Review Analysis Report.[41]

NEMT Statistics	
Total Adjusted Expenditures CY 2019	$27,213,979
Total Members Utilizing Services in CY 2019	49,177
CY 2019 Over CY 2018 Change in Members Utilizing Services	5.88%
Total Active Providers CY 2019	213
CY 2019 Over CY 2018 Change in Active Providers	26.04%

Table 6. NEMT expenditure and utilization data.

The Department contracted with a new statewide NEMT broker, Intelliride, effective August 1, 2020 to help improve customer services to both members and county partners. This change is intended to streamline operations and infrastructure, improve access for members, and reduce administrative burden on counties.[42]

Rate Comparison Analysis

On average, Colorado Medicaid payment for NEMT services are estimated at 37.51% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[43]

NEMT Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$27,213,979	$72,546,529	**37.51%**

Table 7. Comparison of Colorado Medicaid NEMT service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $48,332,550 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. Of the 16 procedure codes analyzed in this service grouping, five were compared to Medicare and 11 were compared to an average of 14 other states' Medicaid rates.[44] The individual rate ratios were 27.06%-134.51%.[45]

[41] Data from the 2016 Medicaid Provider Rate Review Analysis Report is based on claims data, which does not include expenditures from July 2014-November 2014 because the previous broker did not submit claims to the MMIS.
[42] For more information, see the NEMT web page.
[43] Detailed information regarding the rate comparison analysis methodology is contained in Appendix B.
[44] States used in the NEMT rate comparison analysis were Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, and Wisconsin. The Department expanded its review of NEMT services to include four more states than the previous review in the 2016 Medicaid Provider Rate Review Analysis Report. For more details on NEMT rate comparisons, see Appendix B.
[45] Individual rate ratios for each procedure code are contained in Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for NEMT services increased by 1.28% from an average of 62.19 utilizers per provider in CY 2018 to 62.98 utilizers per provider in CY 2019.[46] Additionally:

- In urban counties, panel size averaged 107.95 in CY 2018 and decreased to 107.06 in CY 2019.
- In rural counties, panel size averaged 30.99 in CY 2018 and increased to 32.10 in CY 2019.
- In frontier counties, panel size averaged 15.32 in CY 2018 and increased to 15.58 in CY 2019.

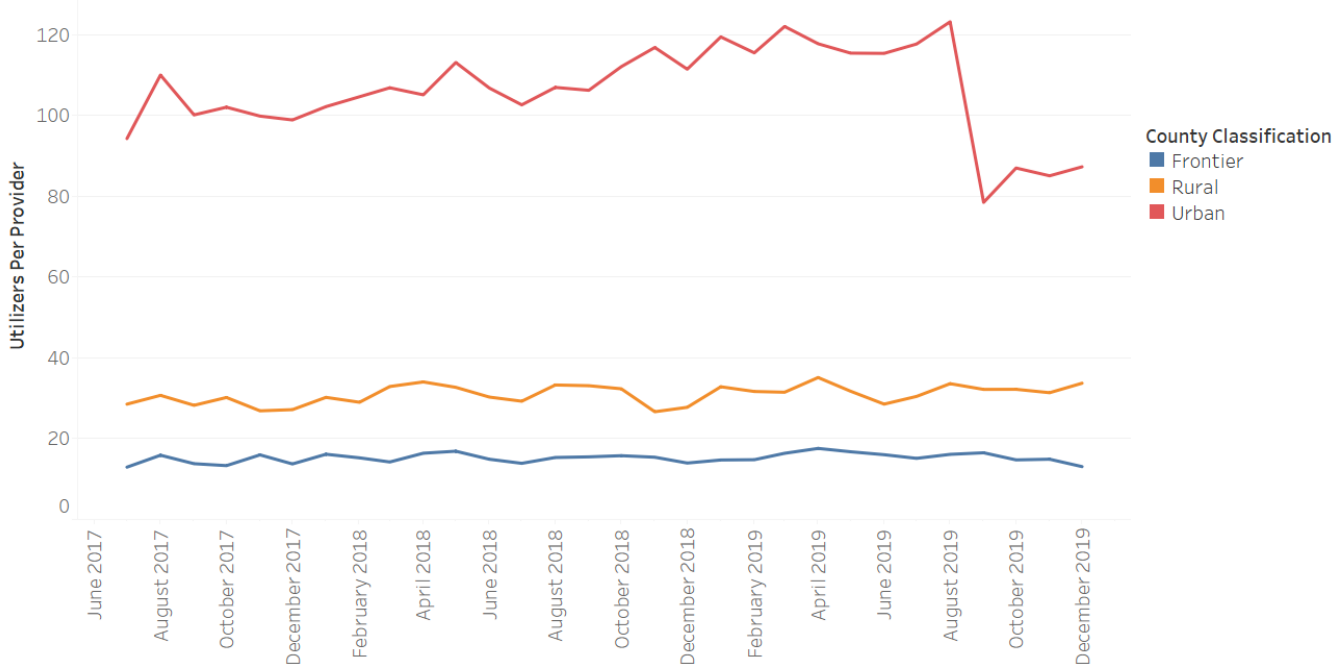

Figure 7. Utilizers per provider (panel size) for NEMT services between July 2017 to December 2019.

Analysis indicates that there were increases in the number of distinct utilizers over this time across urban county classifications. Both distinct utilizers and active providers remained relatively stable in rural and frontier counties.

The increase in distinct utilizers observed in urban counties, compared to the relatively steady number of active providers, led to an increased number of utilizers per provider in those counties.[47]

There was a noticeable change from August 2019 to October 2019 that can be attributed to an issue with claims in the MMIS, which is still being rectified. This will be noted and re-analyzed when claims have been adjusted to more accurately reflect utilization.

[46] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[47] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of NEMT services reside throughout the state. Denver County had the highest number of utilizers at 8,951 in CY 2019.

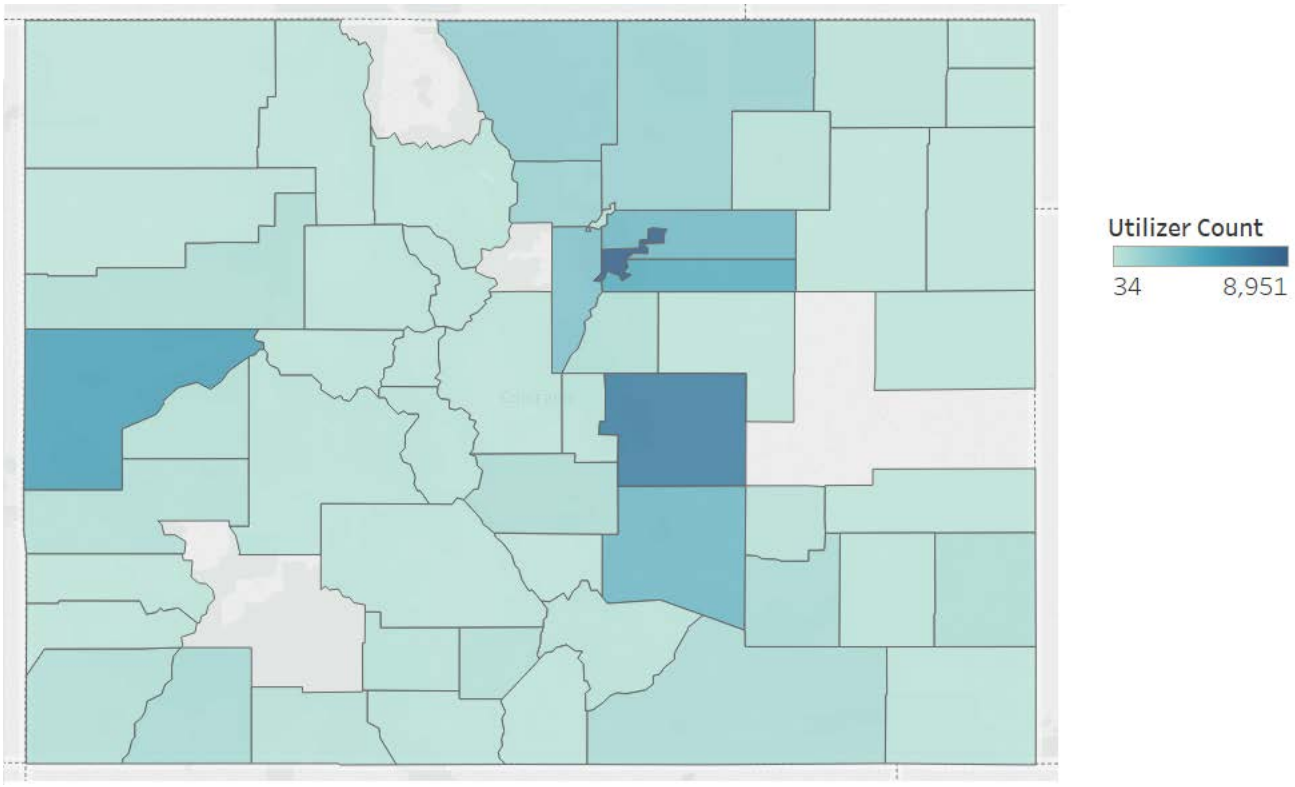

Figure 8. Utilizer density for NEMT services by member county for CY 2019.[48]

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

- relatively lower demand for NEMT services, or a low number of Colorado Medicaid members utilizing NEMT services.

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.

[48] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for NEMT services in CY 2019 ranged from 12.4 in Elbert County to 242.7 in Crowley County.

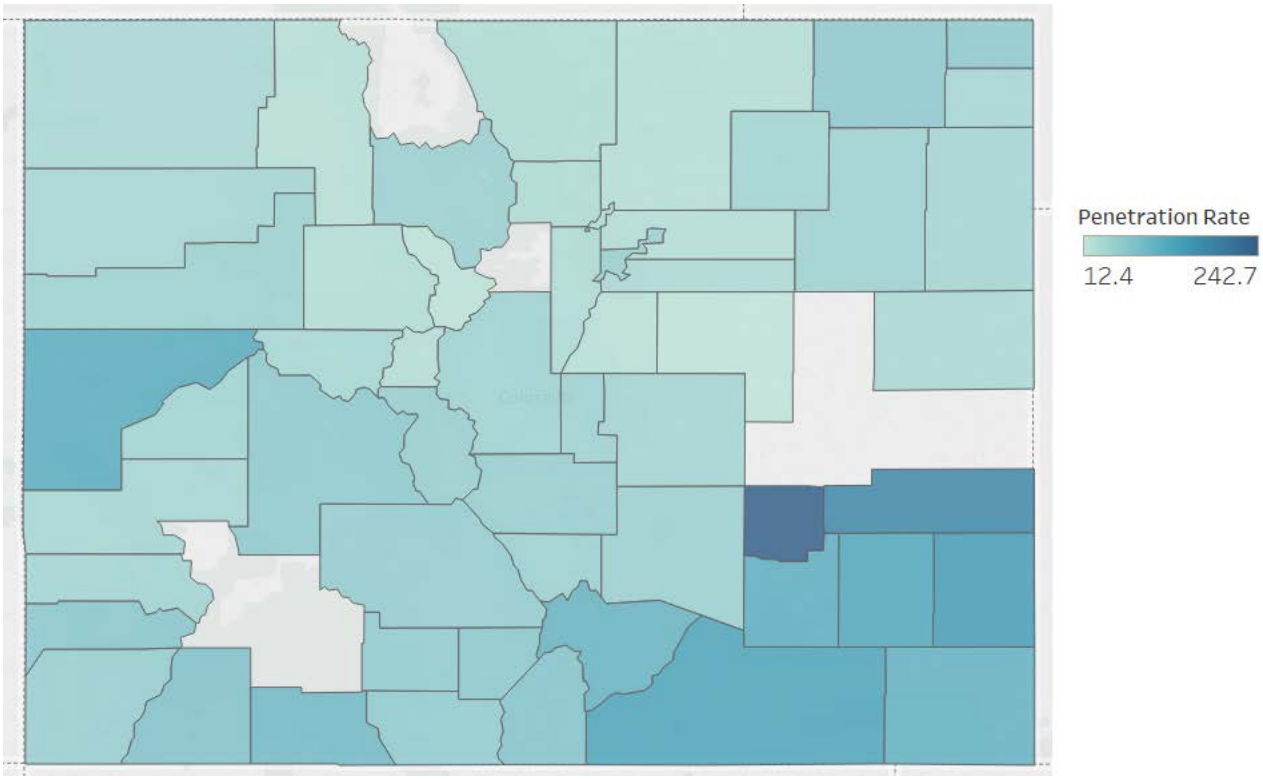

Figure 9. Penetration rates for NEMT services by member county in CY 2019.

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

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.

Member-to-Provider Ratios

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

NEMT Member-to-Provider Ratios			
Region	**CY 2019 NEMT Providers**	**CY 2019 Total Colorado Medicaid Members**	**Providers per 1,000 Members**
Frontier	105	48,210	2.18
Rural	137	179,929	0.76
Urban	183	1,357,110	0.13
Statewide	**213**	**1,478,090**	**0.14**

Table 8. Member-to-provider ratio for NEMT services expressed as providers per 1,000 members by county classification in CY 2019.[49]

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.[50]

[49] Number of providers indicates provider dispatch locations that have submitted claims, not individual providers or individual service delivery providers.

[50] Currently, the Department does not use member-to-provider ratio standards specific to NEMT 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 total Colorado Medicaid members that live within certain drive time bands from where NEMT service locations are indicated. [51]

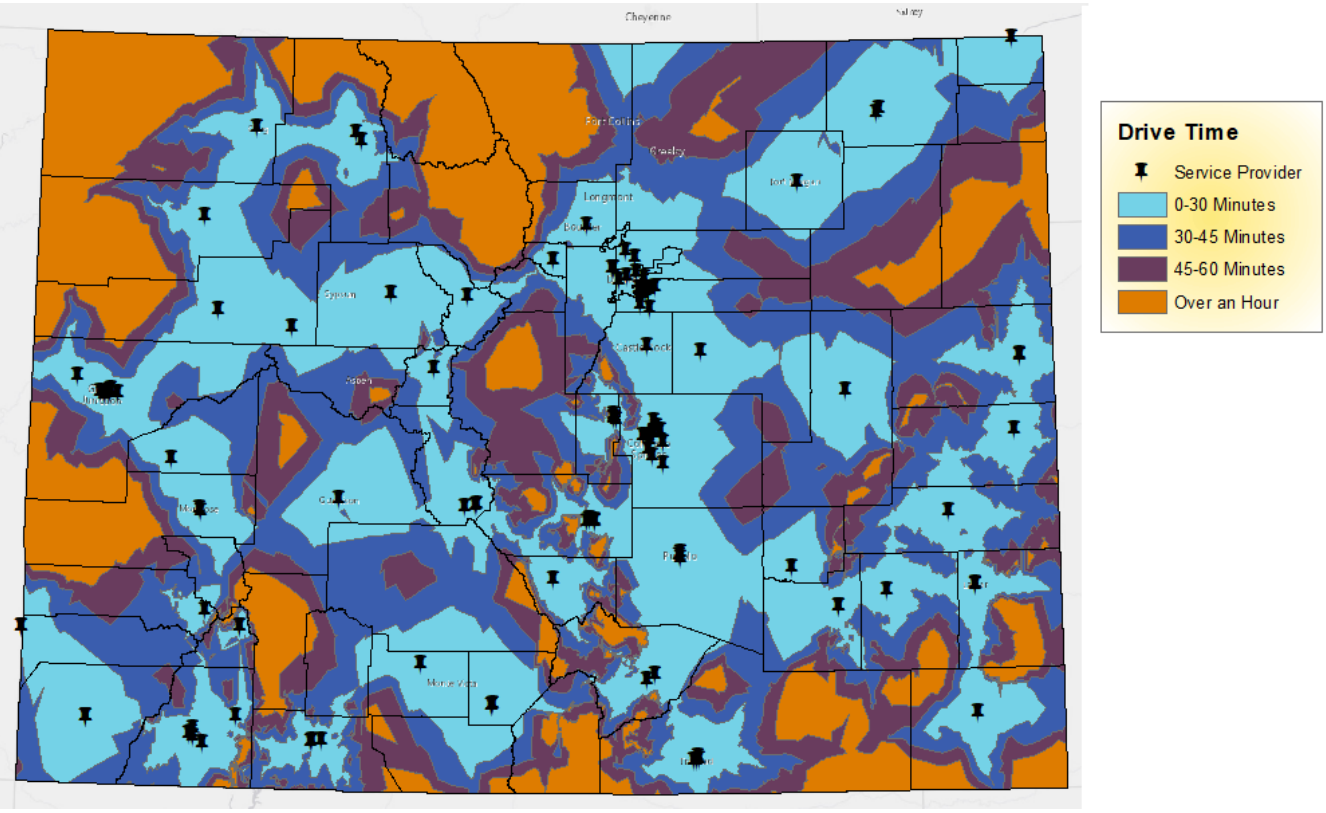

Figure 10. ArcGIS map of drive times of NEMT service locations to members in CY 2019.

Overall, 87.40% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from an NEMT provider. Additionally, 5.99% of total members resided approximately 30-45 minutes from an NEMT provider; 5.96% of total members resided 45-60 minutes from an NEMT provider. Finally, 0.65% of total members resided over an hour from an NEMT provider.

[51] Due to claims data, service locations shown on the ArcGIS map represent provider dispatch locations. Service locations represent dispatch location of providers that have submitted claims, not all auxiliary agencies or individual service delivery providers.

Stakeholder Feedback

Themes of stakeholder feedback and committee member comments from the Medicaid Provider Rate Review Process public meeting on February 5, 2021,[52] as well as feedback received by Department staff regarding NEMT services, are summarized below.

- Providers indicate that rates are reportedly too low to ensure provider retention and appropriate access to high-value services.

Additional Considerations

Other considerations include:

- Both total members accessing NEMT services and total active NEMT providers increased since these services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report. In addition, total expenditures increased by over $40 million;[53]
- The average penetration rate for four counties (Moffat, Routt, Jackson, and Rio Blanco) significantly increased from below the state average in FY 2014-15 to above the state average in CY 2019.[54]
- As a result of the rate review team working with the Governor's Office in response to the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of NEMT services, effective July 2017;[55]
- NEMT providers are provided a brokerage fee by the Department, which is subject to contracted value-based obligations that may impact total fee reimbursed to the provider;[56]
- Many Medicaid recipients in rural areas are already vehicle-dependent due to the lack of public transportation infrastructure, which may impact use of NEMT services in those regions;
- Data, collected after the CY 2019 base data, suggests transportation services may have been disproportionately impacted by the COVID-19 pandemic, and further impacted by the evolving and increasing use of telemedicine services;[57] and
- The total number of billing providers does not represent the total number of service delivery providers employed by agencies providing NEMT services.

Additional Research

The Department is continuing to monitor transportation claims data and utilization trends to identify if there is an ongoing issue related to the COVID-19 pandemic or telemedicine services, and the impact on access to care and provider retention.[58]

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[52] The meeting recording for the MPRRAC meeting on February 5, 2021 can be found on the Rate Review Process Public Meetings web page.
[53] Total member count, provider count, and paid dollars from the 2016 Medicaid Provider Rate Review Analysis Report is based on claims data from FY 2014-15, which does not include expenditures from July 2014- November 2014 because the previous broker did not submit claims into the MMIS.
[54] Penetration rate averaged 0.9 in these four counties in FY 2014-15 and 5.88 in CY 2019.
[55] NEMT services also received a TRI of 6.61%, effective July 2018.
[56] For more information, see the NEMT web page.
[57] For more information, see Appendix J.
[58] For more information, see Appendix J.

Conclusion

Analyses suggest that NEMT rates at 37.51% of the benchmark were sufficient for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[59]

The primary factors that led to this conclusion included:

- Increases in benchmark comparison data;
- Transportation providers may be disproportionately impacted by external factors, including, but not limited to a public health emergency or increasing use of telemedicine services; and
- Significant increase in distinct utilizers and active providers over time.

[59] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.

Waiver for Persons with Brain Injury (BI)

Service Description

The Waiver for Persons with Brain Injury (BI) service grouping, for the purposes of this report, is comprised of 9 procedure codes.[60] BI services provide a home or community-based alternative to hospital or specialized nursing facility care for persons with a brain injury aged 16 and older. Service groupings[61] reviewed under the BI waiver include:[62]

- Adult Day Services
- Independent Life Skills Training (ILST)
- Non-Medical Transportation (NMT)
- Personal Care
- Respite
- Therapy – Behavioral[63]

BI Statistics	
Total Adjusted Expenditures CY 2019	$4,188,806
Total Members Utilizing Services in CY 2019	593
CY 2019 Over CY 2018 Change in Members Utilizing Services	4.40%
Total Active Providers CY 2019	177
CY 2019 Over CY 2018 Change in Billing Providers	4.12%

Table 9. BI expenditure and utilization data.

The BI waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for BI services are estimated at 116.80% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[64]

BI Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$4,188,806	$3,550,275	**116.80%**

Table 10. Comparison of Colorado Medicaid BI service payments to those of other payers, expressed as a percentage (CY 2019).

[60] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure code and modifier combinations excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the BI waiver, see the Health First Colorado Fee Schedule.
[61] A list of procedure codes included in each service grouping is contained in Appendix F.
[62] A list of services included under the adult day and therapy – behavioral service groupings is contained in Appendix F.
[63] For the purposes of this report, therapy – behavioral services under the BI waiver include mental health and substance abuse counseling for individual, group, and family. For more details on the services under therapy – behavioral group on each waiver, see Appendix F.
[64] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

The estimated fiscal impact to Colorado Medicaid would be a savings of $638,531 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 9 revenue codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[65] The individual rate ratios for BI services were 91.14%-316.65%.[66] A summary of Colorado's BI expenditures described as a percentage relative to the expenditures of the other six states is presented below.

BI Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	124.63%	164.44%	98.12%	115.09%	119.94%	115.97%

Table 11. Comparison of Colorado Medicaid BI service payments to those of six other states, expressed as a percentage (CY 2019).[67]

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's BI service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

BI Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Adult Day	$410,834	$418,158	**98.25%**
Independent Life Skills Training (ILST)	$2,210,875	$1,698,299	**130.18%**
Non-Medical Transportation (NMT)	$101,676	$81,135	**125.32%**
Personal Care	$1,333,589	$1,262,414	**105.64%**
Respite	$25,821	$24,197	**106.71%**
Therapy – Behavioral	$41,708	$45,764	**91.14%**

Table 12. Comparison of Colorado Medicaid BI service grouping payments to those of other payers, expressed as a percentage (CY 2019).[68]

[65] States used in the BI rate comparison analysis were Connecticut, Montana, North Dakota, Ohio, Oklahoma, and Utah.
[66] Individual rate ratios for each service grouping are contained in the Aggregate Waiver Services section of this report.
[67] Individual rate ratios by waiver service grouping for each state are contained in Appendix C.
[68] Individual rate ratios by state for each service grouping are contained in Appendix C.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for BI services decreased by 2.06% from an average of 3.82 utilizers per provider in CY 2018 to 3.74 utilizers per provider in CY 2019.[69] Additionally:

- In urban counties, average panel size decreased from 4.06 in CY 2018 to 3.89 in CY 2019.

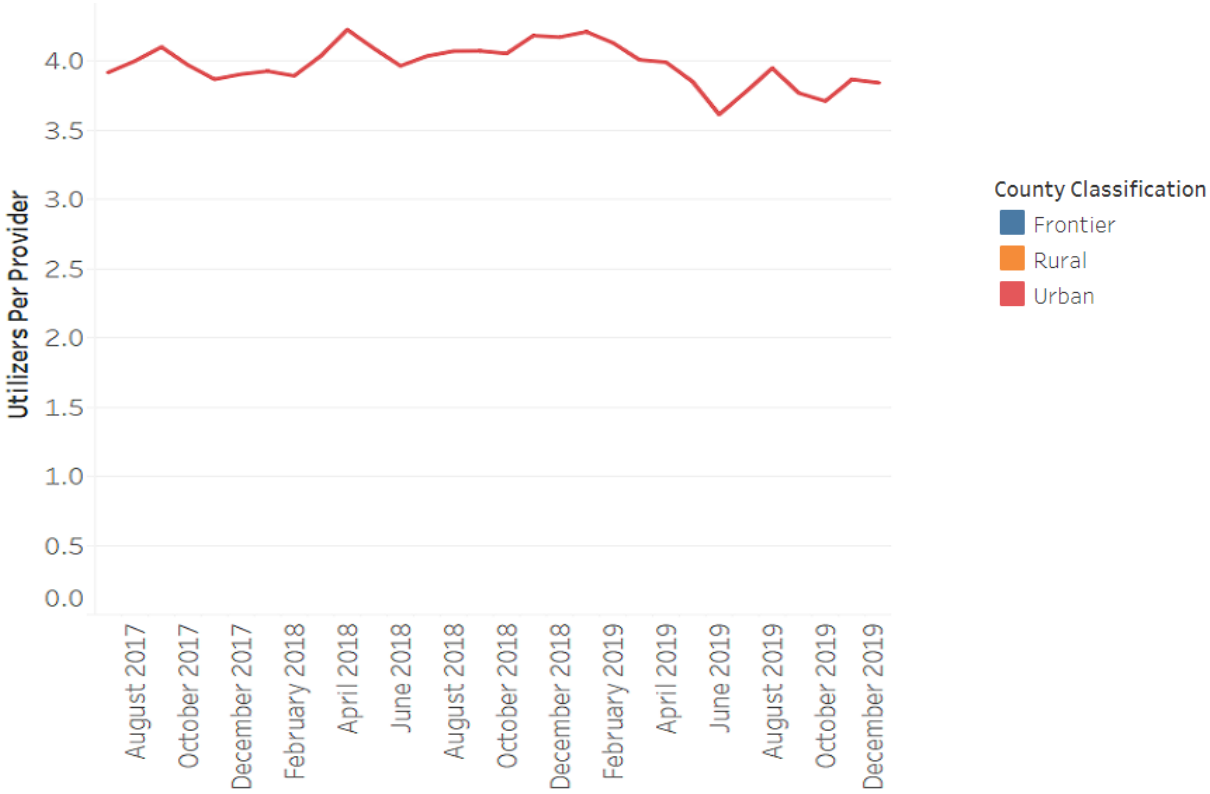

Figure 11. Utilizers per provider (panel size) for BI services between July 2017 to December 2019.[70]

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across urban county classifications.[71]

The distinct utilizers increased at a slightly slower rate than the increase in active providers observed in urban counties, which led to a slight decrease in panel size in those counties. These results indicate that the increase in utilizers did not impact access or limit provider capacity.[72]

[69] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present. Average panel size indicates the monthly average of utilizers per provider.
[70] Some data has been blinded for PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.
[71] For data specific to distinct utilizer and active providers, please see Appendix C.
[72] The Department plans to further identify provider agency caregivers and relative caregivers when there is a full year of data available through Electronic Visit Verification (EVV), which will further inform provider capacity and availability analyses.

Utilizer Density

The utilizer density metric depicts the distribution of members utilizing BI services throughout the state. El Paso County had the highest number of utilizers at 113 in CY 2019.

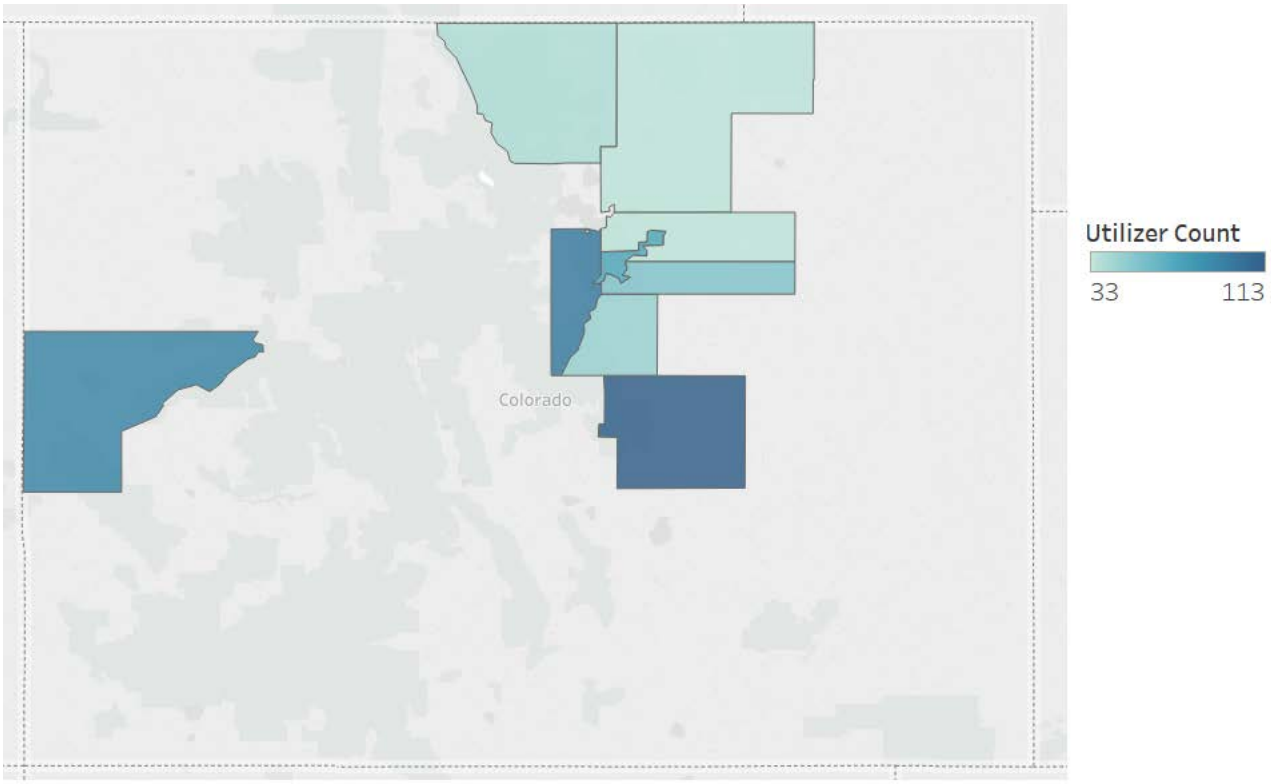

Figure 12. Utilizer density for BI services by county for CY 2019.[73]

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

- relatively lower demand for BI services, or a low number of Colorado Medicaid members utilizing BI services; or
- members are utilizing services not included in this report that are available under the BI waiver.[74]

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.

[73] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.
[74] Detailed information regarding rate review methodology is contained in Appendix C. For a list of all BI services available to eligible Health First Colorado members, see the Health First Colorado Fee Schedule.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service.[75] Penetration rates for BI services in CY 2019 ranged from 0.24 in Adams County to 2.18 in Mesa County.

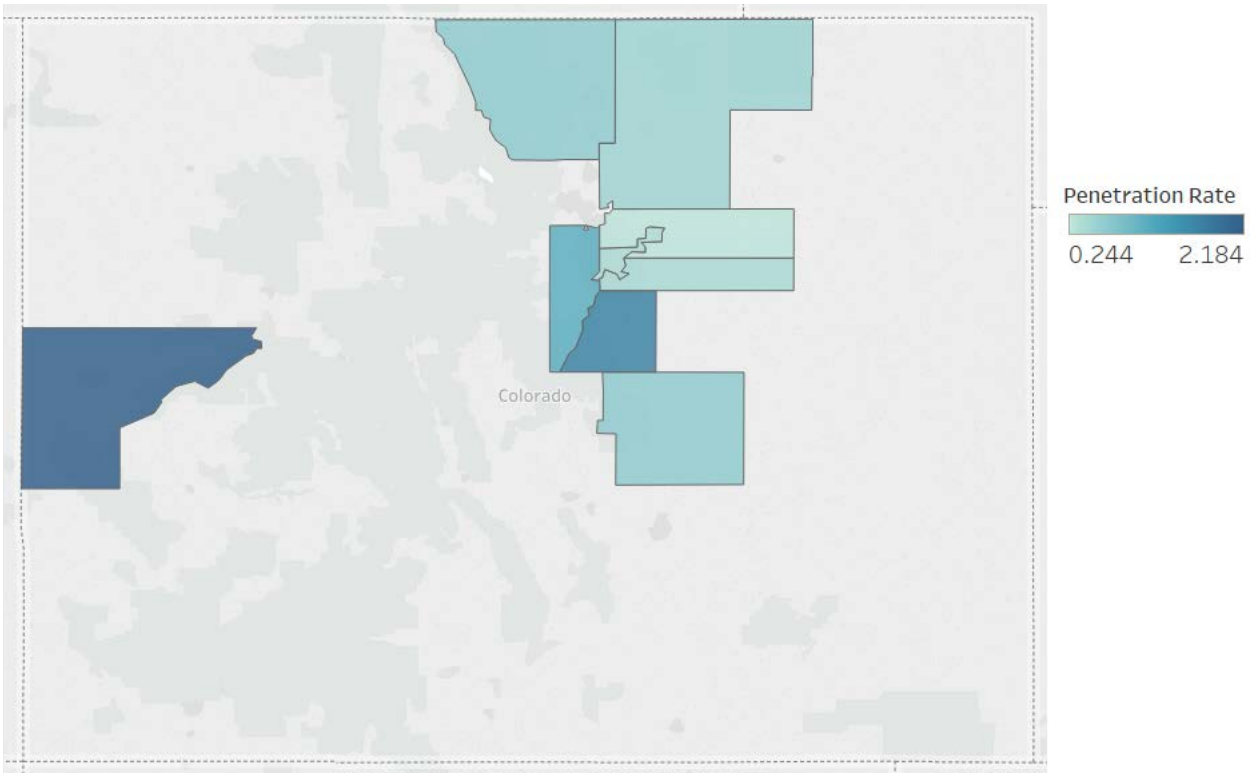

Figure 13. Penetration rates for BI services by county in CY 2019.

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

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.

[75] Penetration rates are calculated as utilizers per 1,000 Colorado Medicaid members.

Member-to-Provider Ratios

The member-to-provider ratio for the BI waiver is calculated as the total number of active BI service providers per 1,000 members ages 16 and older.

BI Member-to-Provider Ratios			
Region	**CY 2019 BI Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 16+**	**Providers per 1,000 Members**
Frontier	4	31,284	0.13
Rural	11	113,872	0.10
Urban	171	844,198	0.20
Statewide	**177**	**989,861**	**0.18**

Table 13. Member-to-provider ratio for BI services expressed as providers per 1,000 members by county classification in CY 2019. [76]

The member-to-provider ratio results indicate that there are fewer providers per 1,000 members in frontier counties than there are in urban counties, and more providers per 1,000 members in urban counties than there are in both rural and frontier counties. The primary driver of these results is the fact that, while there are more Colorado Medicaid members in urban counties, there are significantly more providers in urban counties than when compared to other regions.[77]

[76] Number of providers may indicate provider agencies that have submitted claims, not individual providers or caregivers, as well as relative Certified Nurse Aids (CNAs) or caregivers.

[77] Currently, the Department does not use member-to-provider ratio standards specific to BI 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 total Colorado Medicaid members that live within certain drive time bands from where BI services are provided.[78]

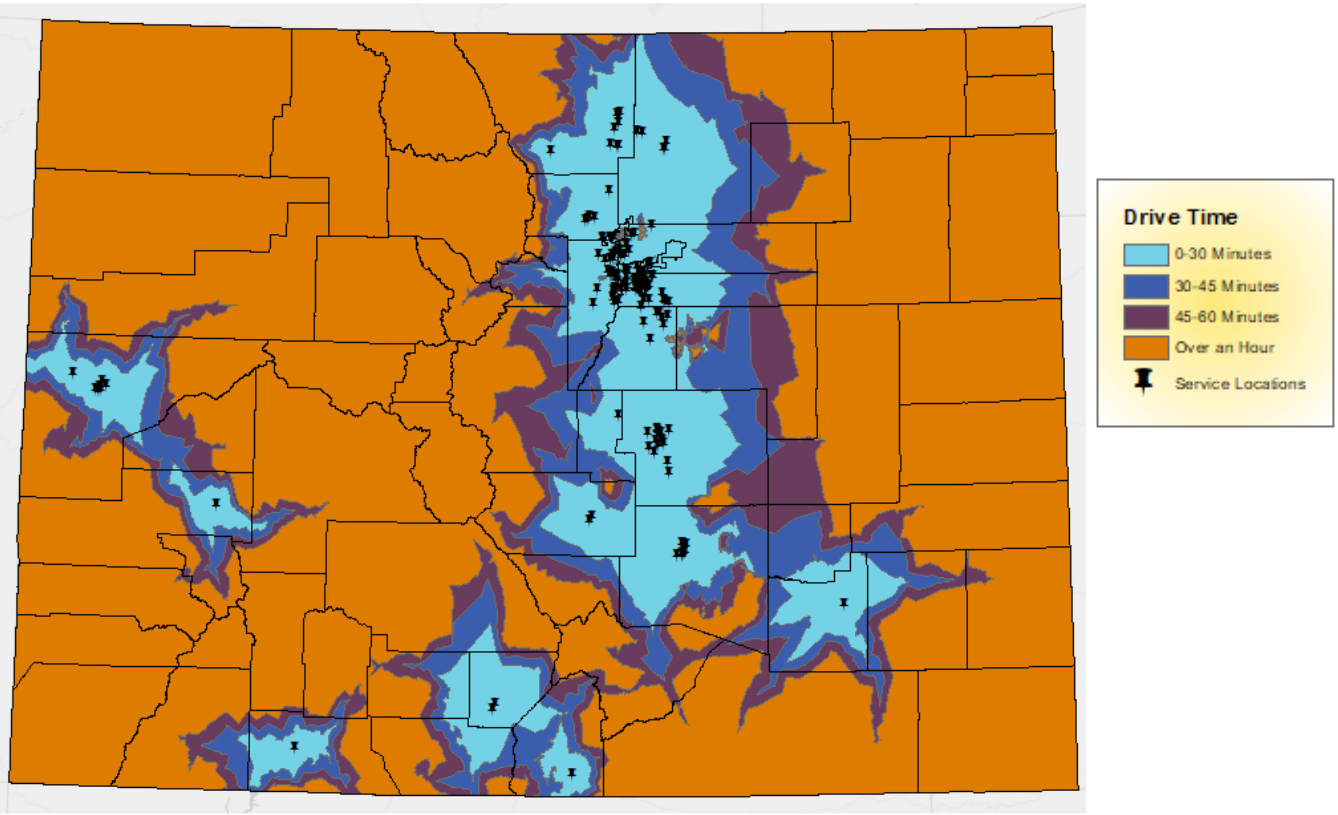

Figure 14. ArcGIS map of drive times of BI service locations to total members in CY 2019.

Overall, 87.83% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a BI provider. Additionally, 2.58% of the total members resided approximately 30-45 minutes from a BI provider; 2.56% of the total members resided 45-60 minutes from a BI provider. Finally, 7.23% of total members resided over an hour from a BI provider.

[78] Due to claims data, service locations shown on the ArcGIS map represent provider service locations. BI services are provided in home and community-based settings and caregivers are not necessarily located where the service locations are shown on the map. Service locations may represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public quarterly meeting on February 5, 2021,[79] as well as feedback received by subject matter experts (SMEs) at the Department, is summarized below.

- Transitional Living Program (TLP) services are offered by a limited number of providers since they are unable to provide the level of care necessary for the current reimbursement rate, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services
- Provider agencies of personal care services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.
- Provider agencies of personal care services in rural areas also expressed concerns regarding the discrepancies between rural rates and Denver County rates.
- Mental health counseling under the BI waiver has a reportedly low number of providers, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services.
- Adult day rates are reportedly too low to continue to provide the same level of services to Medicaid members.
- HCBS Final Rule established new requirements that increased administrative burden on providers of adult day services, yet the rate was not changed to reflect the added time and resources to complete these requirements.[80]

Additional Considerations

Other considerations include:

- In September 2020, an additional procedure code was added to adult day services on this waiver to provide a billable 15-minute unit;
- As of January 2020, the unit for the Independent Life Skills Training (ISLT) reimbursement rate changed from a 1-hour unit to a 15-minute unit;
- The Department is working with providers to identify opportunities for improving access to care to TLP services;
- There has been an increase in total adjusted expenditures, total utilizers, and providers since BI services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;
- BI providers and utilizers increased by over 4% between CY 2018 and CY 2019;
- BI services are performed in a home or community-based setting;
- BI services are sometimes provided by parent or family Certified Nursing Aids (CNAs) or relative caregivers;
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services;
- The total number of active providers does not represent the total number of caregivers employed by agencies providing BI services;

[79] The meeting recording for the public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review Process web page.
[80] For more information on the HCBS Final Rule, see the HCBS Settings Final Rule web page.

- Provider service locations do not encompass all brick-and-mortar agency locations (e.g., the service may be provided in locations other than provider service locations; access to providers is not limited to service locations indicated on ArcGIS map);
- Transitional Living Program (TLP) is highly specialized and reimburses based on levels of complexity; other states' Medicaid programs do not have a service that fully encompasses totality of services provided through Colorado's HCBS Transitional Living Program;
- The Department is currently investigating rate setting methodology for TLP services; and
- Day treatment services were not utilized in CY 2019 and there were no providers of day treatment services for Colorado Medicaid; the cause of this is not clear and the Department is continuing to investigate whether these services are accessed under other waivers, if there is no need for these services for members enrolled on the BI waiver, the benefit is too confusing for providers, the service could benefit from a rate change, among other factors.

Additional Research

The Department plans to further investigate factors that may be causing the lack of day treatment service providers for the BI waiver (mentioned in the Additional Considerations section above). The Department is also continuing to investigate TLP rate setting methodology and identify areas for improving member access to and provider capacity for TLP services.

Conclusion

Analyses suggest BI rates at 116.80% of the benchmark were sufficient for member access and provider retention.

Primary factors that led to this conclusion:

- Increases in distinct utilizers and active providers over time;
- Decreasing panel size indicating that the increase in utilizers did not negatively impact access or provider capacity;
- Utilizer density, provider locations, and other access to care metrics remained consistent from the previous review cycle and did not indicate any new access concerns;[81]
- The Department is currently working on addressing TLP rate setting methodology; and
- Addition of the billable 15-minute unit for adult day services.

[81] For more details on the previous BI rate review analysis, see the 2017 Medicaid Provider Rate Review Analysis Report.

Waiver for Persons with Developmental Disabilities (DD)

Service Description

The Waiver for Persons with Developmental Disabilities (DD), for the purposes of this report, is comprised of 11 procedure codes.[82] The DD waiver provides services and supports which allow persons with developmental disabilities, aged 18 and older, to continue to live in the community.[83] Service groupings reviewed under the DD waiver include:[84]

- Community Transitions
- Day Habilitation
- Home Delivered Meals
- Non-Medical Transportation (NMT)
- Prevocational Services
- Residential Habilitation[85]
- Supported Employment
- Therapy – Behavioral[86]

DD Statistics	
Total Adjusted Expenditures CY 2019	$459,457,947
Total Members Utilizing Services in CY 2019	6,679
CY 2019 Over CY 2018 Change in Members Utilizing Services	9.35%
Total Active Providers CY 2019	547
CY 2019 Over CY 2018 Change in Active Providers	6.42%

Table 14. DD expenditure and utilization data.

The DD waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for DD waiver services are estimated at 103.81% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[87]

[82] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the DD waiver, see the Health First Colorado Fee Schedule.
[83] There is currently a waitlist for member enrollment on this waiver. For more information, see the Waiting Lists and Enrollment web page.
[84] A list of procedure codes included in each service grouping is contained in Appendix F.
[85] For the purposes of this report, residential habilitation services include group residential services and supports, individual residential services and supports, and individual residential services and supports/host homes. For more details on the services provided under residential habilitation, see the Long-Term Services and Supports Benefits and Services Glossary.
[86] For the purposes of this report, therapy – behavioral services include line staff, counseling (group and individual), consultation, and behavioral plan assessment. For more details on the services reviewed under therapy – behavioral on each waiver, see Appendix F.
[87] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

DD Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$459,457,947	$442,582,321	**103.81%**

Table 15. Comparison of Colorado Medicaid DD service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $16,875,626 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 11 procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[88] The DD individual rate ratios ranged from 43.89%-347.42%.[89] A summary of Colorado's DD expenditures described as a percentage relative to the expenditures of the other six states is presented below.

DD Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	96.3%	151.4%	108.0%	113.0%	112.8%	72.9%

Table 16. Comparison of Colorado Medicaid DD service payments to those of six other states, expressed as a percentage (CY 2019).[90]

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's DD service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

DD Service Grouping Rate Benchmark Comparisons			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Community Transitions	PHI	PHI	**136.06%**
Day Habilitation[91]	$76,269,560	$89,779,525	**84.95%**
Home Delivered Meals	$666	$345	**193.13%**
Non-Medical Transportation (NMT)	$15,298,528	$18,892,378	**80.98%**
Prevocational Services	$1,657,692	$1,918,761	**86.39%**
Residential Habilitation	$332,486,308	$300,410,489	**110.68%**
Supported Employment	$24,884,029	$25,346,432	**98.18%**
Therapy – Behavioral	$8,861,156	$6,234,384	**142.13%**

Table 17. Comparison of Colorado Medicaid DD service grouping payments to those of other payers, expressed as a percentage (CY 2019).[92]

[88] States used in the DD rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[89] Individual rate ratios for each service grouping are contained in the Aggregate Waiver Services section of this report.
[90] Individual rate ratios by waiver service grouping for each state are contained in Appendix C.
[91] Procedure code T2021 for specialized habilitation and supported community connections includes seven levels of care on the DD waiver; these services are also available on the SLS waiver but only include six levels of service, accounting for the difference in rate benchmark comparisons for the same service across waivers. Rate comparison methodology is contained in Appendix C. For more service grouping information, see Appendix F. For detailed reimbursement rate information, see the Health First Colorado Fee Schedule.
[92] Individual rate ratios by state for each service grouping are contained in Appendix C.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for DD services increased by 2.30% from an average of 11.18 utilizers per provider in CY 2018 to 11.44 utilizers per provider in CY 2019.[93] Additionally:

- In urban counties, panel size averaged 12.93 in CY 2018 and increased to 13.24 in CY 2019.
- In rural counties, panel size averaged 6.40 in CY 2018 and decreased to 6.21 in CY 2019.
- In frontier counties, panel size averaged 3.95 in CY 2018 and decreased 3.74 in CY 2019.

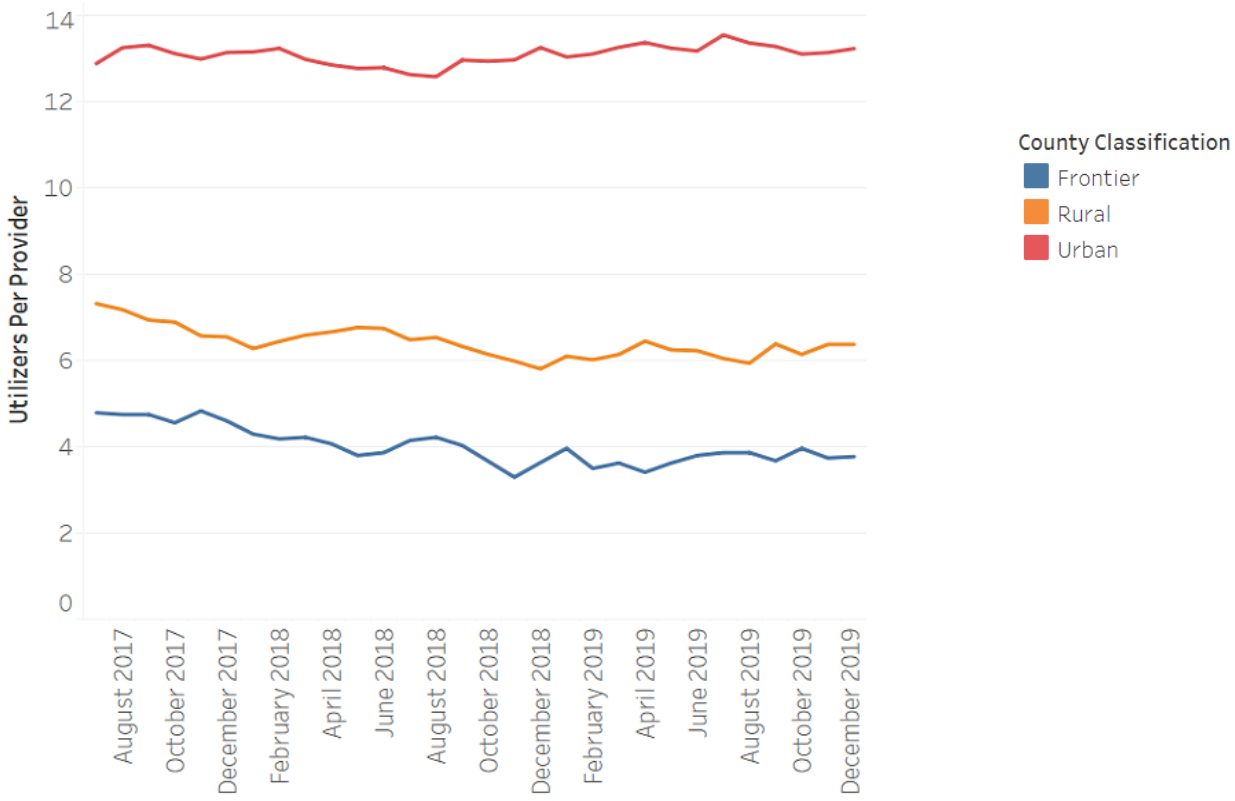

Figure 15. Utilizers per provider (panel size) for DD services from July 2017 to December 2019.

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across the urban county classification. Additionally, active providers increased across rural and frontier county classifications.[94]

The number of distinct utilizers and active providers increased at a similar rate over time, which led to relatively stable panel size in urban counties over time. Additionally, the increase in active providers compared to relatively stable number of distinct utilizers led to a slight decrease in panel size across rural and frontier counties over time. These results indicate that while utilizers increased, member access to care and provider capacity was not negatively impacted.

[93] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[94] For data specific to distinct utilizer and active providers, see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of DD services reside throughout the state. Arapahoe County had the highest number of utilizers at 1,274 in CY 2019.

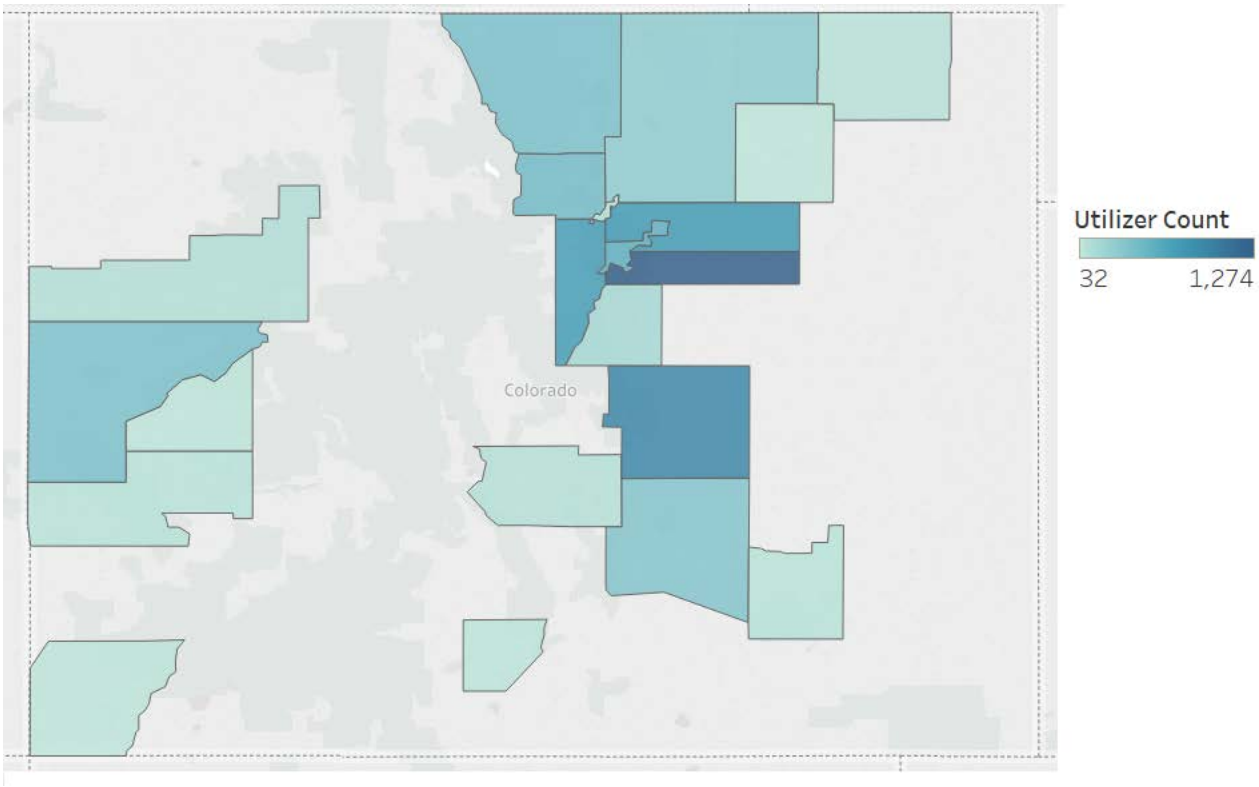

Figure 16. Utilizer density for DD services by county for CY 2019.[95]

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

- relatively lower demand for DD services, or a low number of Colorado Medicaid members utilizing DD services.

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.

[95] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for DD services in CY 2019 ranged from 2.94 in Denver County to 14.64 in Logan County.

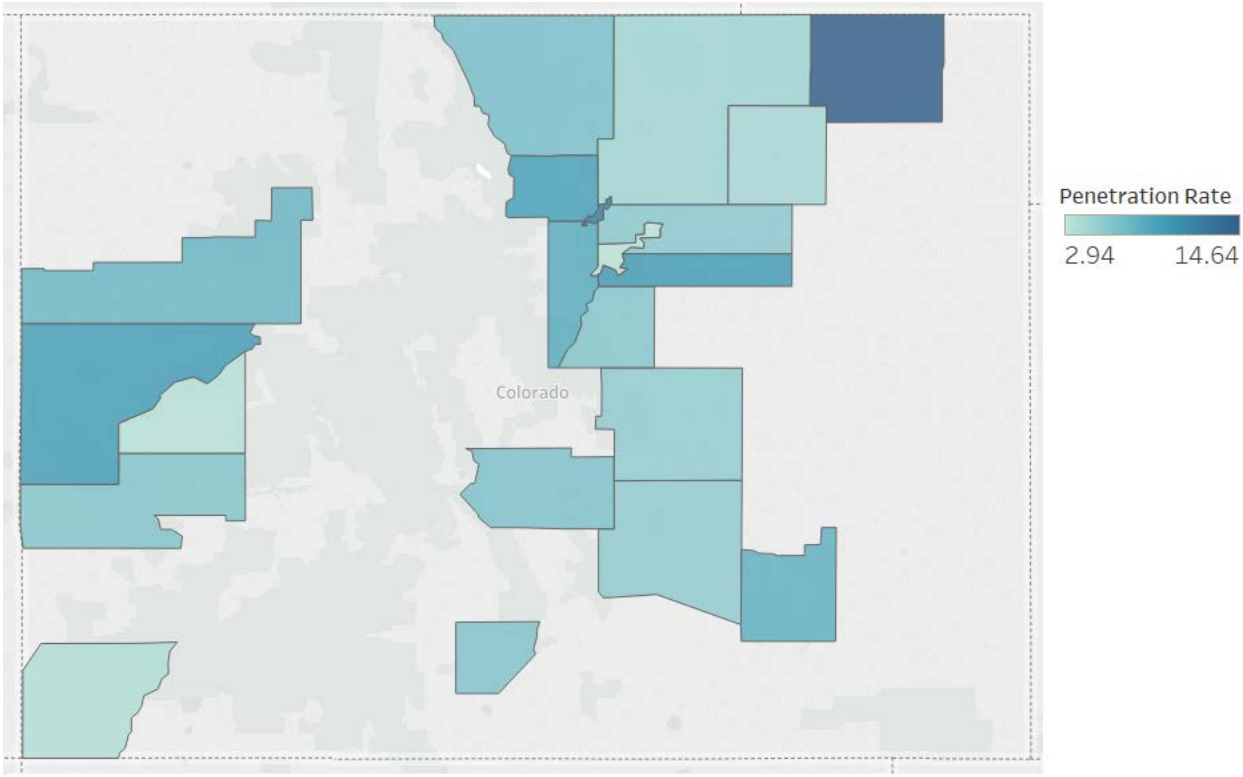

Figure 17. Penetration rates for DD services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the DD waiver is calculated as the total number of active DD service providers per 1,000 members ages 18 and older.

DD Member-to-Provider Ratios			
Region	**CY 2019 DD Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 18+**	**Providers per 1,000 Members**
Frontier	45	28,365	1.59
Rural	121	102,729	1.18
Urban	477	755,426	0.63
Statewide	**547**	**886,520**	**0.62**

Table 18. Member-to-provider ratio for DD services expressed as providers per 1,000 members by county classification in CY 2019.

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.[96]

[96] Currently, the Department does not use member-to-provider ratio standards specific to DD 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 total Colorado Medicaid members that live within certain drive time bands from where DD services were provided in CY 2019.[97]

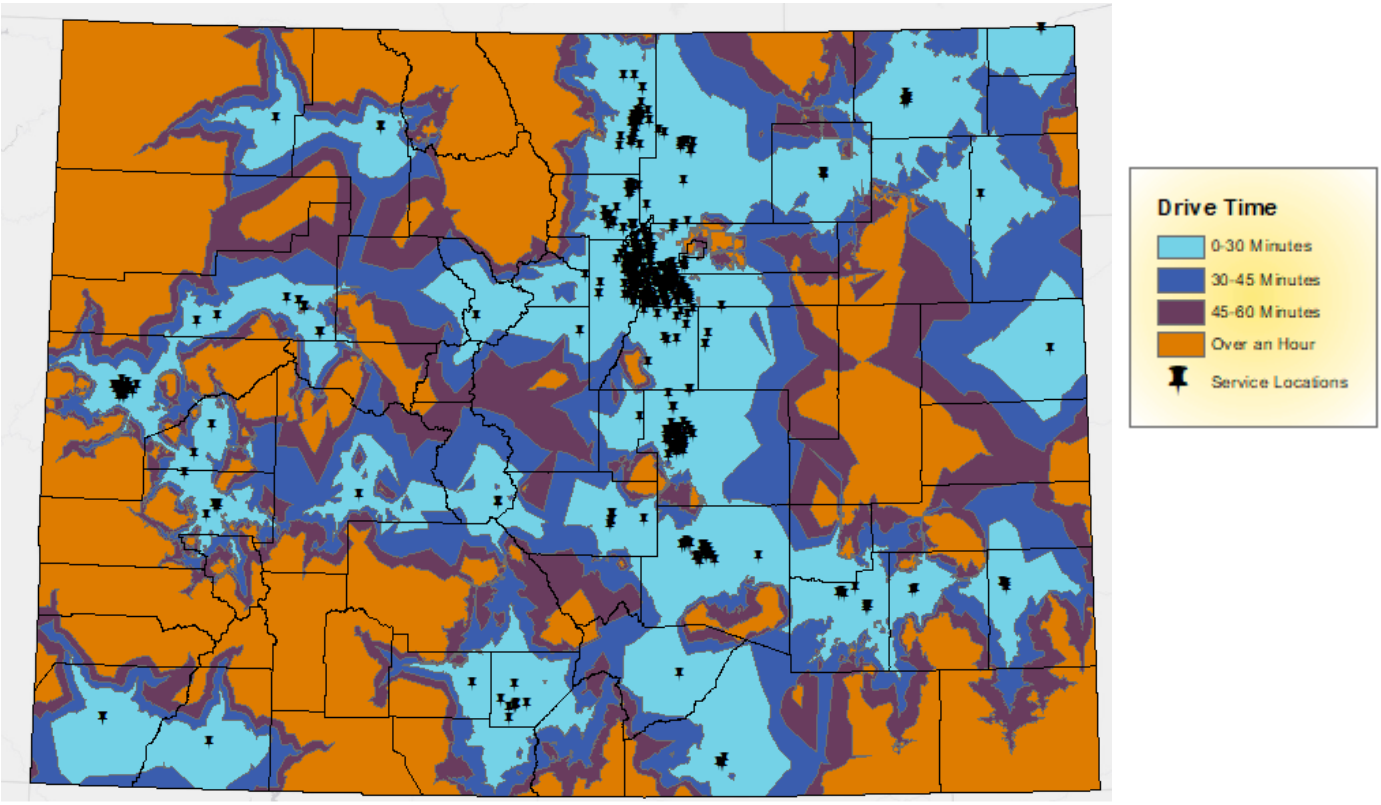

Figure 18. ArcGIS map of drive times of DD service locations to total members in CY 2019.

Overall, 95.66% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a DD provider. Additionally, 2.48% of total members resided approximately 30-45 minutes from a DD provider; 0.81% of total members resided 45-60 minutes from a DD provider. Finally, 1.05% of total members resided over an hour from a DD provider.

[97] Due to claims data, service locations shown on the ArcGIS map represent provider service locations. Service locations represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public quarterly meeting on February 5, 2021,[98] as well as feedback received by subject matter experts (SMEs) at the Department, is summarized below.

- Unit limits for behavioral services are reportedly too low to provide frequency of care preferred by providers and utilizers of these services.
- Job development services under the supported employment service grouping have low rates and working with Division of Vocation Rehabilitation (DVR) to receive adequate reimbursement for these services is confusing.[99]

Additional Considerations

Other considerations include:

- In 2017, prevocational services at 39.22%-162.12% of the benchmark were flagged as an area where there may be access to care issues; analyses reveal that prevocational services on the DD waiver have increased to 48.94%-195.52% of the benchmark. Additionally, specialized habilitation services have become the preferential method for providing these types of services;[100]
- A new procedure code was temporarily added for specialized day habilitation to provide one-on-one individualized service; the Department is investigating if this service should be permanently added to day habilitation services;
- Additional procedure code for individualized day habilitation services and the addition of virtual service delivery methods are expected to increase member access to these services; and
- Some providers are concerned requirements for residential habilitation due to rule changes made in 2019 regarding Individual Residential Supports and Services (IRSS) settings will impact provider retention since the current rate may not be set at an adequate rate to provide individualized supports.

Additional Research

The Department will continue to investigate factors attributing to the slight decrease in members utilizing prevocational services to determine if member access and provider retention issues exist, if they are unique to Medicaid, and if issues are attributable to rates.

Conclusion

Analyses suggest DD rates at 103.81% of the benchmark were sufficient for member access and provider retention.

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[98] The meeting recording for the public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review Process web page.

[99] DVR is the primary payer for these services; Colorado Medicaid will only cover these services if they are not covered by DVR.

[100] This is in alignment with the statewide initiative to emphasize competitive integrated employment as an Employment First state.

The primary factors that led to this conclusion included:

- Increases in total expenditures, distinct utilizers, and active providers of DD services since previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;
- The year-over-year change for utilizers and providers continues to increase by 9.35% and 6.42%, respectively;[101]
- Panel size has remained steady in urban areas over time, and decreased slightly in rural and frontier counties due to an increase in providers, indicating provider capacity is increasing; and
- Utilizers density has remained consistent statewide since previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

[101] Year-over-year data is based on claims data from CY 2018 and CY 2019.

Supported Living Services Waiver (SLS)

Service Description

The Supported Living Services Waiver (SLS) service grouping, for the purposes of this report, is comprised of 17 procedure codes.[102] The SLS Waiver provides persons with developmental disabilities, aged 18 and older, supported living services in the person's home or community. Service groupings reviewed under the SLS waiver include:[103]

- Day Habilitation
- Homemaker
- Non-Medical Transportation (NMT)
- Personal Care
- Prevocational Services
- Professional Therapy Services[104]
- Respite
- Supported Employment
- Therapy – Behavioral[105]

SLS Statistics	
Total Adjusted Expenditures CY 2019	$62,343,392
Total Members Utilizing Services in CY 2019	5,211
CY 2019 Over CY 2018 Change in Members Utilizing Services	(2.63%)
Total Active Providers CY 2019	432
CY 2019 Over CY 2018 Change in Active Providers	8.00%

Table 19. SLS expenditure and utilization data.

The SLS waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for SLS services are estimated at 85.00% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[106]

[102] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from July 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the SLS waiver, see the Health First Colorado Fee Schedule.
[103] A list of procedure codes included in each service grouping is contained in Appendix F.
[104] For the purposes of this report, professional therapy services under the SLS waiver include massage therapy, hippotherapy, and movement therapy services.
[105] For the purposes of this report, therapy – behavioral services under the SLS waiver include behavioral line staff, individual and group counseling, consultation, and behavioral plan assessment.
[106] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

SLS Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$62,343,392	$73,342,057	**85.00%**

Table 20. Comparison of Colorado Medicaid SLS service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $10,998,665 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 17 procedure codes analyzed in this service grouping were compared an average of six other states' Medicaid rates.[107] The SLS individual rate ratios ranged from 35.07%-351.23%.[108] A summary of Colorado's SLS expenditures described as a percentage relative to the expenditures of the other six states is presented below.

SLS Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	52.3%	131.9%	81.2%	117.9%	118.6%	67.5%

Table 21. Comparison of Colorado Medicaid SLS service payments to those of six other states, expressed as a percentage (CY 2019).[109]

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's SLS service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

SLS Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Day Habilitation[110]	$28,080,736	$41,371,975	**67.87%**
Homemaker	$6,406,535	$4,227,321	**151.55%**
Non-Medical Transportation (NMT)	$6,083,823	$7,870,973	**77.29%**
Personal Care	$6,730,159	$5,434,056	**123.85%**
Prevocational Services	$921,757	$1,396,137	**66.02%**
Professional Therapy Services	$1,547,412	$1,355,751	**114.14%**
Supported Employment	$7,105,271	$5,026,567	**141.35%**
Therapy – Behavioral	$4,050,997	$5,674,100	**71.39%**

Table 22. Comparison of Colorado Medicaid SLS service grouping payments to those of other payers, expressed as a percentage (CY 2019).[111]

[107] States used in the SLS rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[108] Individual rate ratios for each waiver service are contained in Appendix C.
[109] Individual rate ratios by waiver service grouping for each state are contained in Appendix C.
[110] Procedure code T2021 for specialized habilitation and Supported Community Connections includes seven levels of care on the DD waiver; these services are also available on the SLS waiver but only include six levels of service, accounting for the difference in rate benchmark comparisons for the same service across waivers. Rate comparison methodology is contained in Appendix C. For more service grouping information, see Appendix F. For detailed reimbursement rate information, see the Health First Colorado Fee Schedule.
[111] Individual rate ratios by state for each service grouping are contained in Appendix C.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for SLS services decreased by 11.94% from an average of 12.93 utilizers per provider in CY 2018 to 11.39 utilizers per provider in CY 2019.[112] Additionally:

- In urban counties, panel size averaged 13.41 in CY 2018 and decreased to 11.70 in CY 2019.
- In rural counties, panel size averaged 11.46 in CY 2018 and decreased to 10.23 in CY 2019.
- In frontier counties, panel size averaged 7.42 in CY 2018 and decreased to 7.32 in CY 2019.

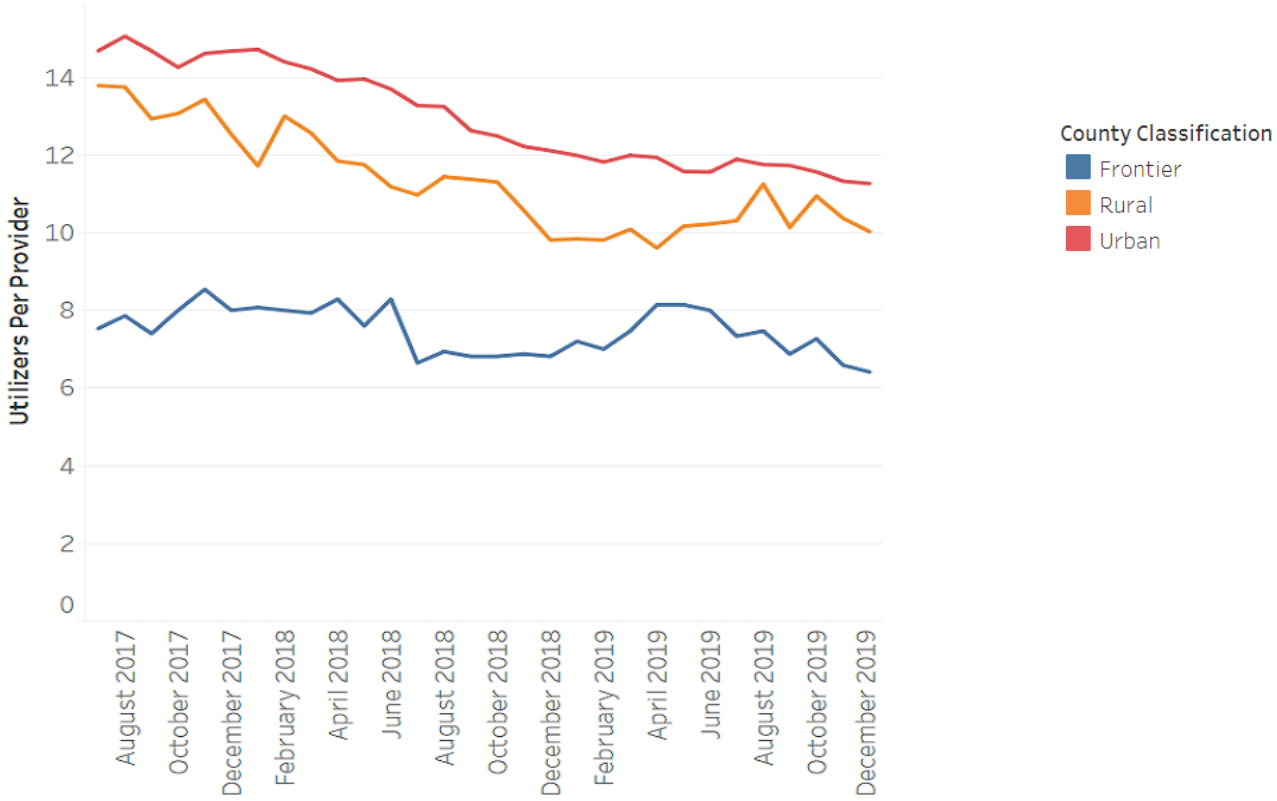

Figure 19. Utilizers per provider (panel size) for SLS services from July 2017 to December 2019.

Analysis indicates that there were increases in the number of active providers over this time across all county classifications. In addition, there was a decrease in the number of distinct utilizers over this time in urban counties, while distinct utilizers remained relatively stable over this time across rural and frontier county classifications

The number of active providers increased over time as the number of distinct utilizers remained relatively stable or decreased over time, which led to a decrease in the number of utilizers per provider across all county classifications.[113]

[112] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[113] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of SLS services reside throughout the state. El Paso County had the highest number of utilizers at 863 in CY 2019.

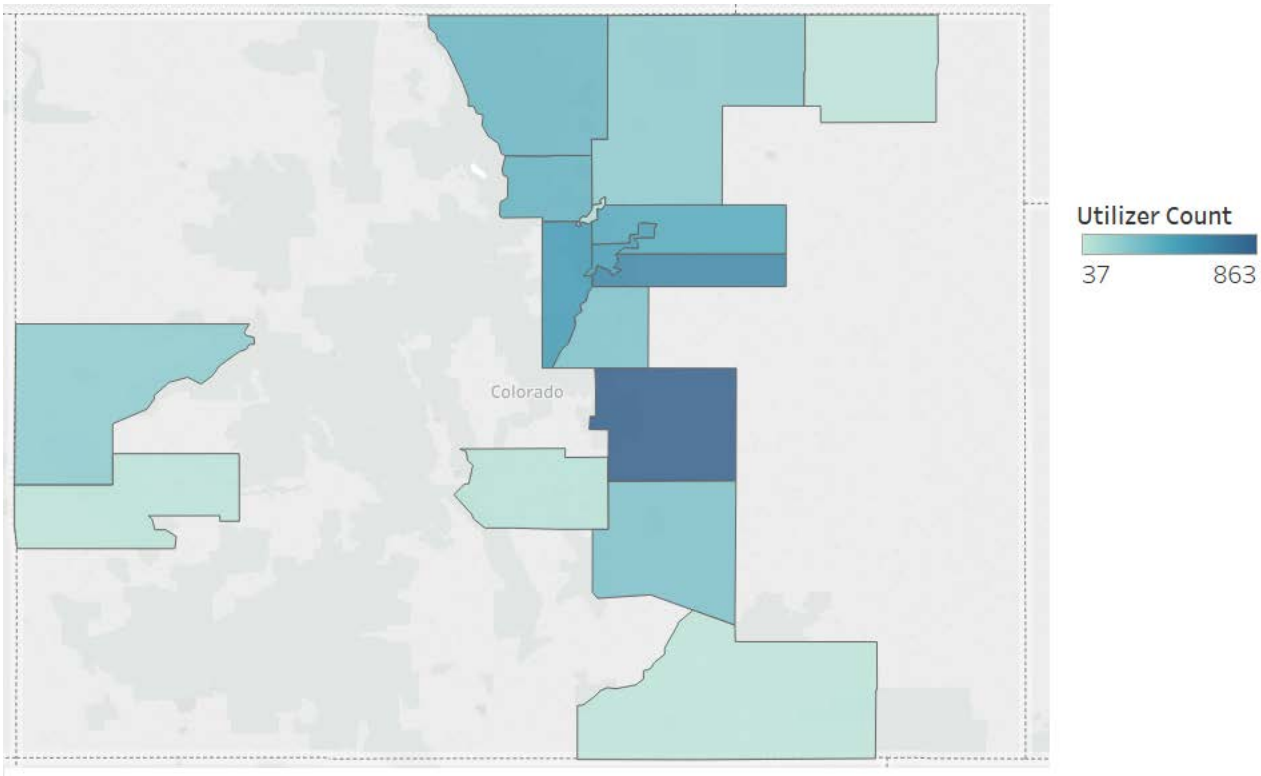

Figure 20. Utilizer density for SLS services by county for CY 2019.[114]

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

- relatively lower demand for SLS services, or a low number of Colorado Medicaid members utilizing SLS services.

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.

[114] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for SLS services in CY 2019 ranged from 2.575 in Denver County to 11.601 in Broomfield County.

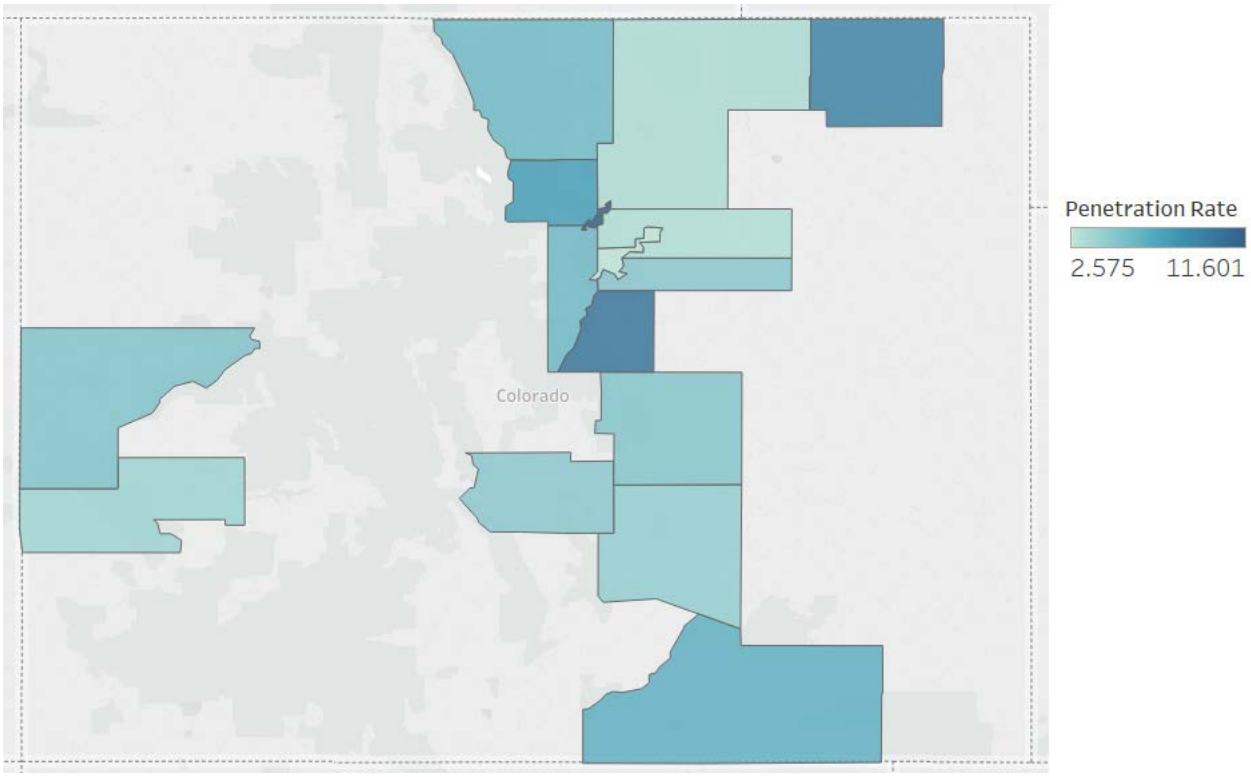

Figure 21. Penetration rates for SLS services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the SLS waiver is calculated as the total number of active SLS service providers per 1,000 members ages 18 and older.

SLS Member-to-Provider Ratios			
Region	**CY 2019 SLS Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 18+**	**Providers per 1,000 Members**
Frontier	21	28,365	0.74
Rural	46	102,729	0.45
Urban	405	755,426	0.54
Statewide	**432**	**886,520**	**0.49**

Table 23. Member-to-provider ratio for SLS services expressed as providers per 1,000 members by county classification in CY 2019.

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 urban counties than there are in rural 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, as well as more SLS service providers, in these counties when compared to other areas.[115] The Department will investigate providers in rural counties to identify if the lower member-to-provider ratio in rural counties is leading to an access issue in those counties, whether or not it is unique to Medicaid, and if they are attributable to rates.

[115] Currently, the Department does not use member-to-provider ratio standards specific to SLS 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 total Colorado Medicaid members that live within certain drive time bands from where SLS services are provided.[116]

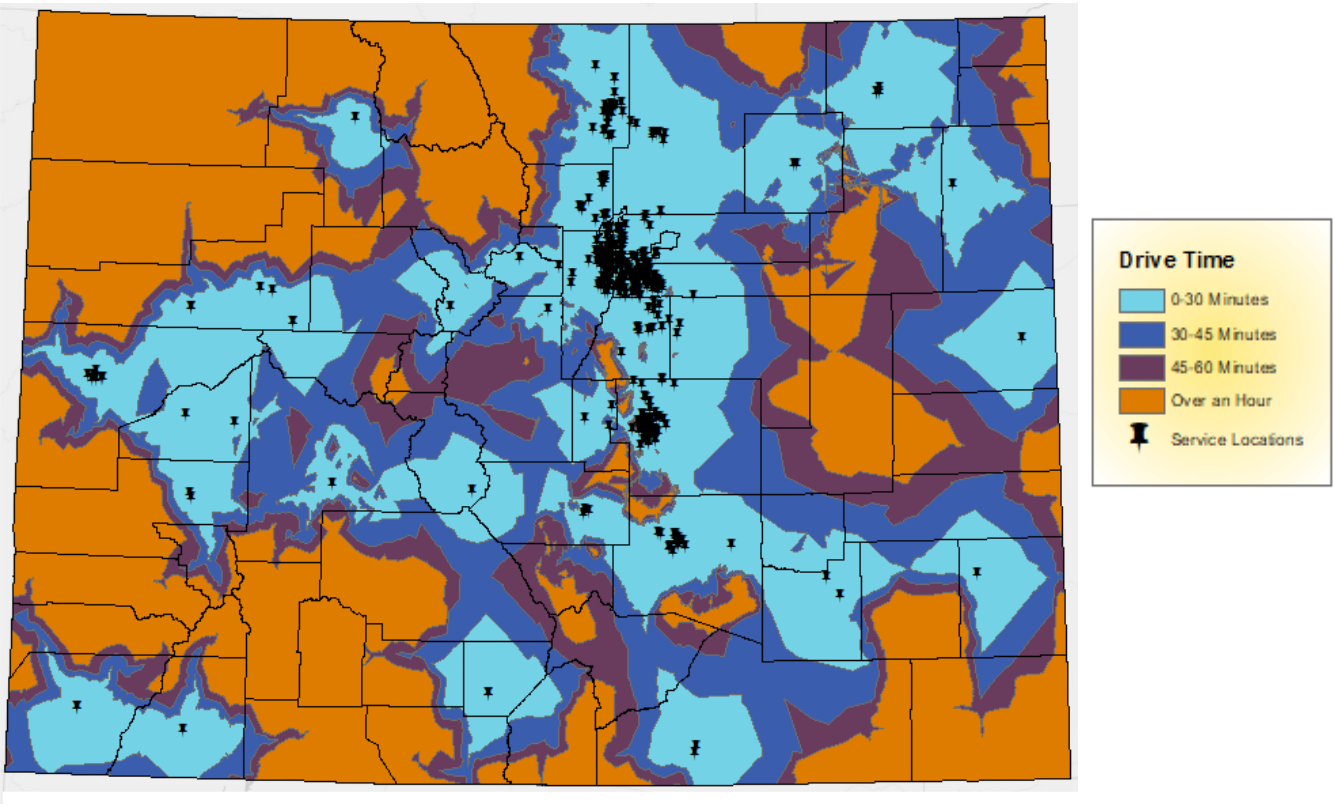

Figure 22. ArcGIS map of drive times from SLS provider service locations to total members in CY 2019.

Overall, 95.45% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a SLS services provider. Additionally, 2.35% of total members resided approximately 30-45 minutes from a SLS services provider; 1.09% of total members resided 45-60 minutes from a SLS services provider. Finally, 1.11% of total members resided over an hour from a SLS services provider.

[116] Due to claims data, service locations shown on the ArcGIS map represent provider service locations. Service locations represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public quarterly meeting on February 5, 2021,[117] as well as feedback received by subject matter experts (SMEs) at the Department, is summarized below.

- Unit limits for behavioral services are reportedly too low to provide frequency of care preferred by providers of and members receiving these services.
- Job development services under the supported employment service grouping have low rates and working with DVR to receive adequate reimbursement for these services is confusing.[118]

Additional Considerations

Additional considerations include:

- Continued efforts are being made to increase the availability of providers in the Front Range and rural areas;
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services; and
- Several reimbursement rates for SLS waiver services vary for the same or similar services provided on other waivers.[119]

Additional Research

The Department will investigate potential attributing factors to the decrease in utilizers in urban counties for SLS services, if this is unique to Medicaid, and whether or not this indicates a potential access to care issue. Additionally, the Department will investigate the low member-to-provider ratio in rural counties to determine if this may be causing potential access issues, if it is unique to Medicaid, and, if so, is it attributable to rates or not. The Department will also further investigate day habilitation rate, the differences across waivers, and their impact on access to care and provider retention, if any.

Conclusion

Analyses suggest SLS rates at 85.00% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- The overall increase in active providers across all county classifications;
- The overall decrease in panel size over time across all county classifications; and
- There were no significant changes in access to care metrics from the previous review in cycle one to indicate a potential access issue.

[117] The meeting recording for the public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review Process web page.
[118] DVR is the primary payer for these services; Colorado Medicaid will only cover these services if they are not covered by DVR.
[119] Some rates are in alignment with DD waiver services. See the Health First Colorado Fee Schedule for more details.

Community Mental Health Supports Waiver (CMHS)

Service Description

The Community Mental Health Supports Waiver (CMHS) service grouping, for the purposes of this report, is comprised of 11 procedure codes.[120] CMHS services provide a home or community-based alternative to nursing facility care for persons experiencing severe and persistent mental health needs aged 18 and older. Services reviewed under the CMHS waiver include:[121]

- Adult Day Services
- Alternative Care Facility (ACF)
- Community Transitions
- Home Delivered Meals
- Homemaker
- Life Skills Training
- Non-Medical Transportation (NMT)
- Personal Care
- Respite[122]

CMHS Statistics	
Total Adjusted Expenditures CY 2019	$44,956,825
Total Members Utilizing Services in CY 2019	3,925
CY 2019 Over CY 2018 Change in Members Utilizing Services	(1.18%)
Total Active Providers CY 2019	564
CY 2019 Over CY 2018 Change in Active Providers	(1.05%)

Table 24. CMHS expenditure and utilization data.

The CMHS waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for CMHS services are estimated at 80.42% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[123]

CMHS Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$44,956,825	$54,659,300	**80.42%**

Table 25. Comparison of Colorado Medicaid CMHS service payments to those of other payers, expressed as a percentage (CY 2019).

[120] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the CMHS waiver, see the Health First Colorado Fee Schedule.
[121] A list of procedure codes included in each service grouping is contained in Appendix F.
[122] In-home respite is not available to members enrolled on the CMHS waiver.
[123] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

The estimated fiscal impact to Colorado Medicaid would be $9,702,475 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 11 procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[124] The individual rate ratios for CMHS services were 38.29%-225.69%.[125] A summary of Colorado's expenditures described as a percentage relative to the expenditures of the other six states is presented below.

CMHS Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	87.9%	81.2%	46.6%	97.6%	112.9%	97.8%

Table 26. Comparison of Colorado Medicaid CMHS service payments to those of six other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's CMHS service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

CMHS Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Adult Day Services	$663,510	$870,550	**76.22%**
Alternative Care Facility (ACF)	$31,253,241	$42,731,033	**73.14%**
Community Transitions	PHI	PHI	**82.88%**
Home Delivered Meals	$25,229	$13,063	**193.13%**
Homemaker	$3,682,566	$3,180,486	**115.79%**
Life Skills Training	$5,500	$4,225	**130.18%**
Non-Medical Transportation (NMT)	$476,590	$384,422	**123.98%**
Personal Care	$7,781,565	$7,366,253	**105.64%**
Respite[126]	$68,770	$107,446	**64.00%**

Table 27. Comparison of Colorado Medicaid CMHS service grouping payments to those of other payers, expressed as a percentage (CY 2019).[127]

[124] States used in the CMHS rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, Utah.
[125] Individual rate ratios for each service grouping by state are contained in Appendix C.
[126] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[127] Individual rate ratios by state for each service grouping are contained in Appendix C.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for CMHS services increased by 0.65% from an average of 6.20 utilizers per provider in CY 2018 to 6.24 utilizers per provider in CY 2019.[128] Additionally:

- In urban counties, panel size averaged 6.98 in CY 2018 and decreased to 6.94 in CY 2019.
- In rural counties, panel size averaged 4.16 in CY 2018 and increased to 4.34 in CY 2019.
- In frontier counties, panel size averaged 2.63 in CY 2018 and increased to 2.80 in CY 2019.

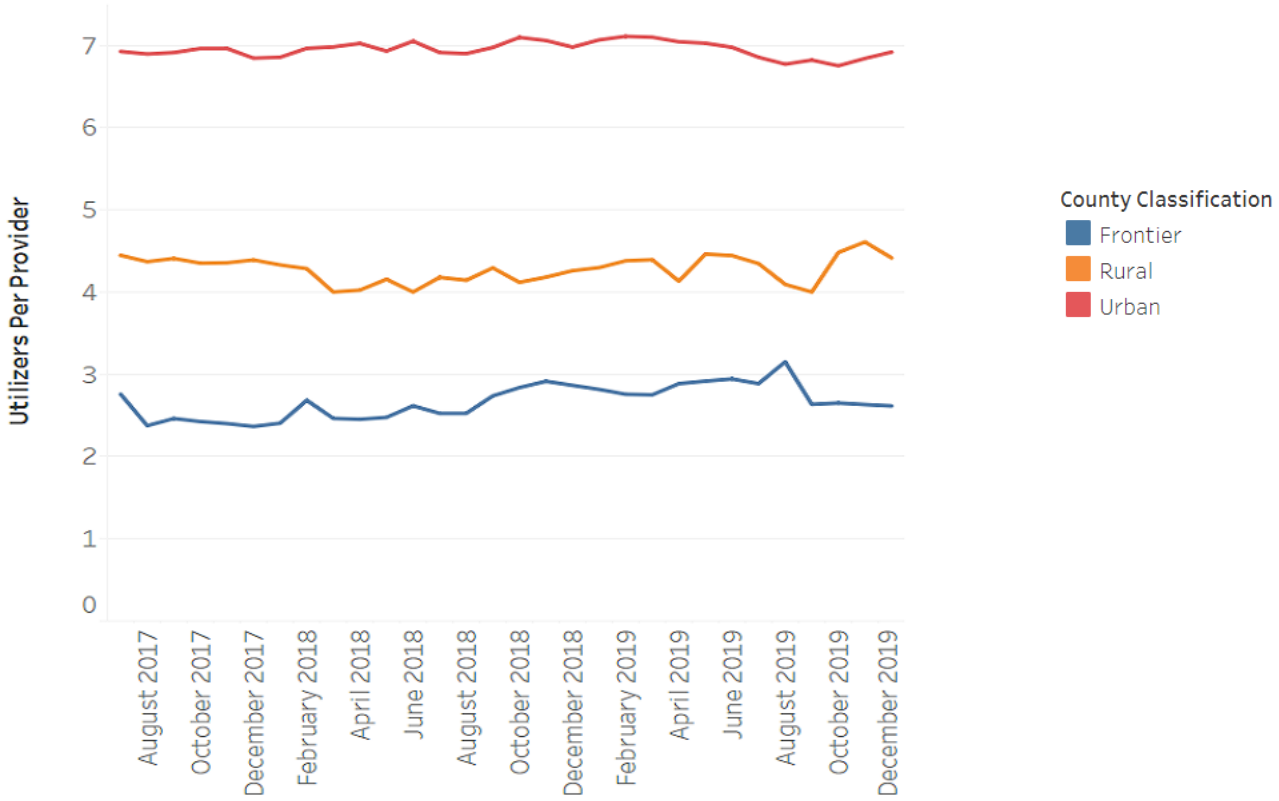

Figure 23. Utilizers per provider (panel size) for CMHS services between July 2017 to December 2019.

Analysis indicates that the number of distinct utilizers and active providers remained relatively steady over this time across all county classifications.

The steady number of distinct utilizers observed across all county classifications, compared to the relatively steady number of active providers, led to a relatively steady panel size across all county classifications over time.[129]

[128] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[129] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of CMHS services reside throughout the state. Denver County had the highest number of utilizers at 652 in CY 2019.

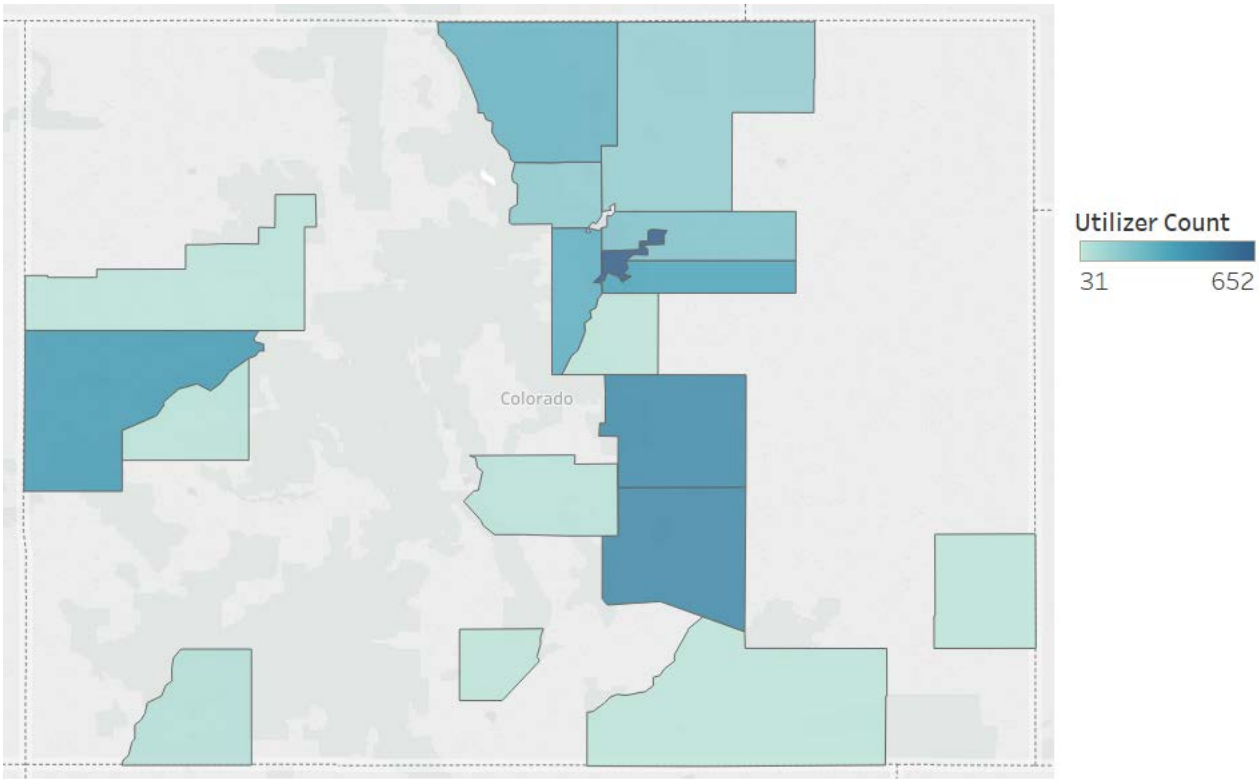

Figure 24. Utilizer density for CMHS services by county for CY 2019.[130]

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

- relatively lower demand for CMHS services, or a low number of Colorado Medicaid members utilizing CMHS services; or
- more Colorado Medicaid members are accessing these services under the EBD waiver in those counties.[131]

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.

[130] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.
[131] The EBD waiver includes all the same services provided under the CMHS waiver, as well as some additional services not available under the CMHS waiver (i.e., IHSS health maintenance activities and in-home respite).

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for CMHS services in CY 2019 ranged from 1.193 in Douglas County to 9.553 in Mesa County.

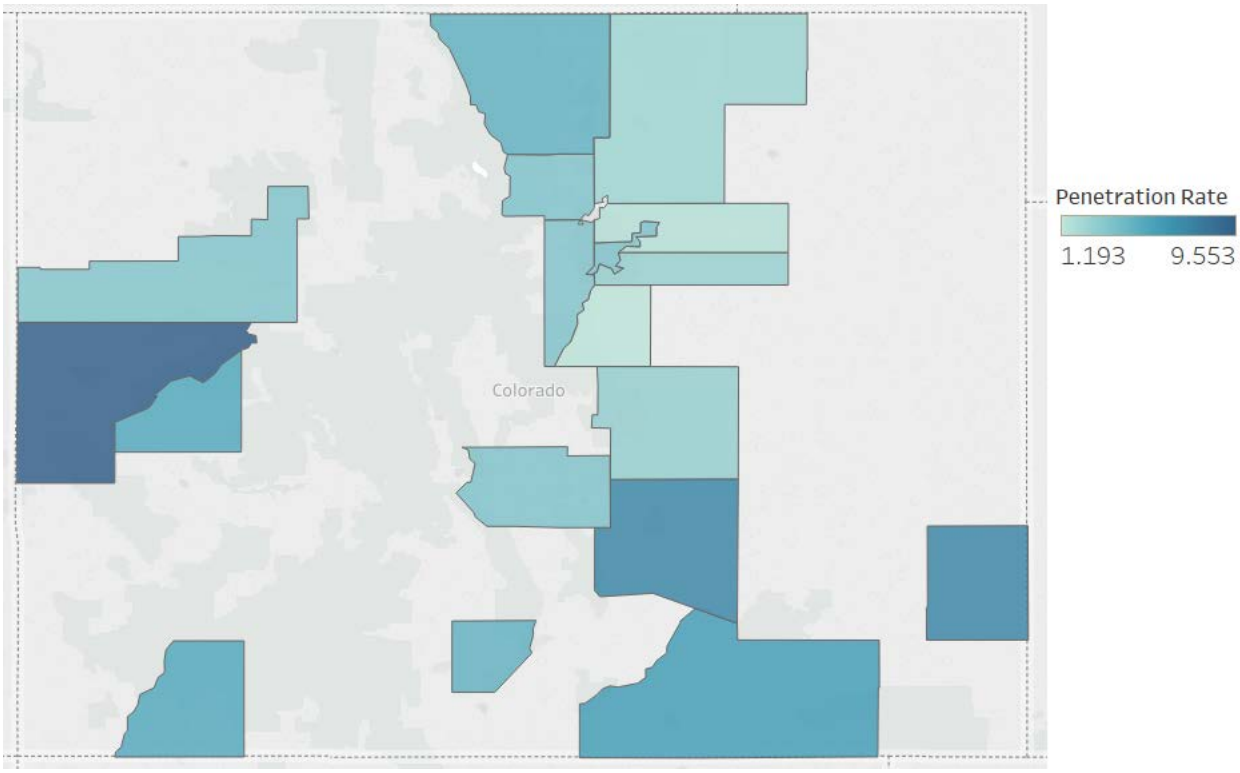

Figure 25. Penetration rates for CMHS services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the CMHS waiver is calculated as the total number of active CMHS service providers per 1,000 members ages 18 and older.

CMHS Member-to-Provider Ratios			
Region	**CY 2019 CMHS Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 18+**	**Providers per 1,000 Members**
Frontier	53	28,365	1.87
Rural	114	102,729	1.11
Urban	478	755,426	0.63
Statewide	**564**	**886,520**	**0.64**

Table 28. Member-to-provider ratio for CMHS services expressed as providers per 1,000 members by county classification in CY 2019. [132]

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.[133]

[132] Number of providers indicates providers that have submitted claims, not individual caregivers.

[133] Currently, the Department does not use member-to-provider ratio standards specific to CMHS 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 total Colorado Medicaid members that live within certain drive time bands from where CMHS services are provided.[134]

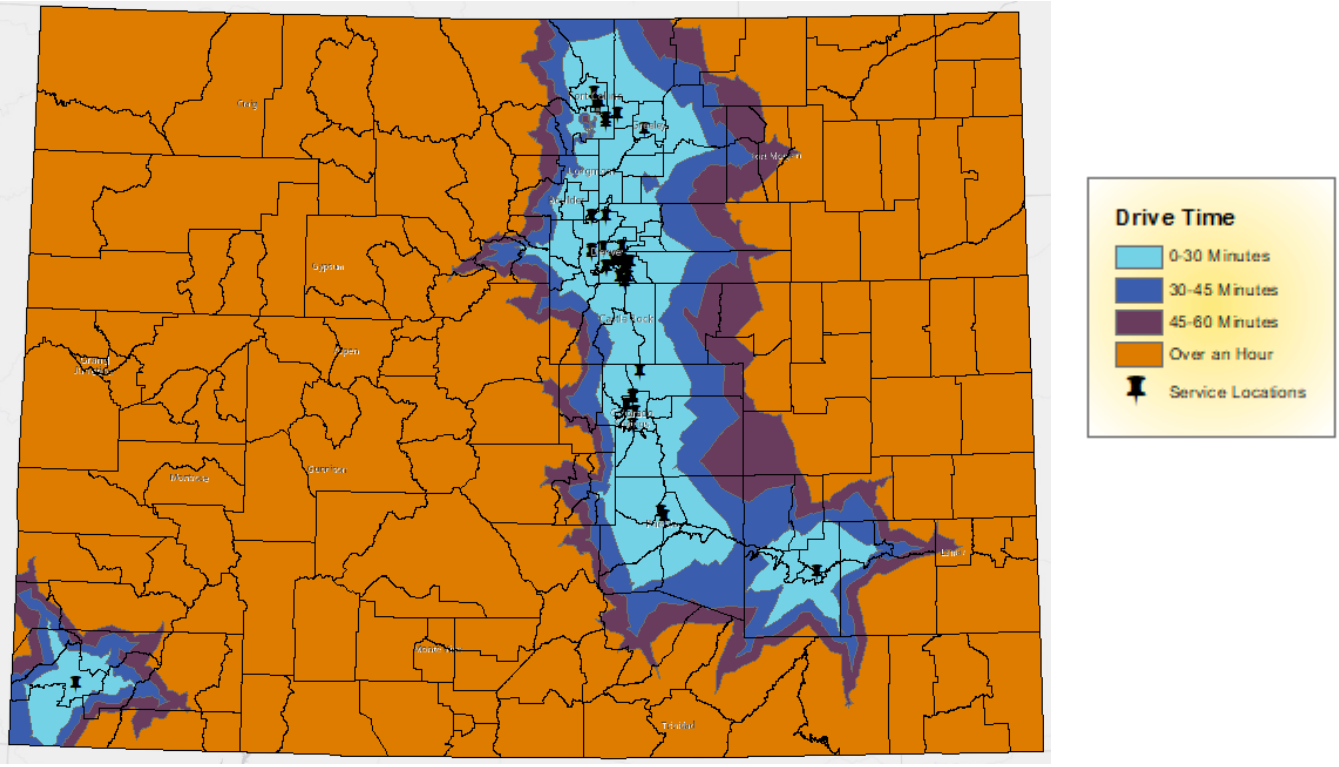

Figure 26. ArcGIS map of drive times of CMHS service locations to total members in CY 2019.

Overall, 94.78% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a CMHS provider. Additionally, 3.06% of total members resided approximately 30-45 minutes from a CMHS provider; 1.02% of total members resided 45-60 minutes from a CMHS provider. Finally, 1.14% of total members resided over an hour from a CMHS provider.

[134] Due to claims data, service locations shown on the ArcGIS map represent provider service locations. Service locations represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[135] as well as stakeholder feedback received by Department staff, is summarized below.

- There are reportedly significant access issues in rural and frontier counties for ACF, adult day, and respite services provided under the CMHS waiver.
- Provider agencies of personal care services in rural areas expressed concerns regarding acquisition and retention of staff due to reportedly low reimbursement rates.
- ACF per diem rates are much lower than other similar levels of assisted living facility-based care provided under Colorado Medicaid HCBS waivers (e.g., nursing facilities).

Additional Considerations

Other considerations include:

- Utilization has decreased on the CMHS waiver from CY 2018 to CY 2019; the Department is aware that utilization has been decreasing and is continuing to investigate the factors attributing to this decrease, whether they are unique to Medicaid, if there is a potential access to care issue, and if rates are attributable to those issues.
- Several reimbursement rates for CMHS waiver services vary for the same or similar services provided on other waivers.[136]
- The Department is investigating the possibility of merging the CMHS waiver with the EBD waiver, but has identified challenges due to the increasing utilization and popularity of IHSS health maintenance activities;
    - in addition, EBD includes IHSS and in-home respite services that are currently not available to members enrolled on the CMHS waiver; merging these waivers is expected to increase expenditures for these services;
- All services available through the CMHS waiver are also available through the EBD waiver, but IHSS and in-home respite are not available to members enrolled in the CMHS waiver;
    - anecdotal evidence indicates members may be preferential to receiving services through the EBD waiver;
- In-home respite is not available on the CMHS waiver but is available on other adult waivers;
- There has been an overall increase in total adjusted expenditures, distinct utilizers, and active providers since the CMHS services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;[137]
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services;

[135] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.
[136] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.
[137] While there has been increases in these metrics since the CMHS waiver was previously reviewed, there was a decrease observed in total expenditures, utilizers, and providers from CY 2018 to CY 2019. The Department is aware of this decrease and continues to monitor and investigate the factors attributing to this decrease.

- The total number of service provider locations does not represent the total number of caregivers or individual service delivery providers of CMHS services; and
- Provider billing locations do not encompass all brick-and-mortar agency locations (e.g., the primary billing provider may also submit claims from auxiliary agency locations).

Additional Research

The Department plans to further investigate decrease in utilization and will continue to investigate the factors attributing to this decrease, whether they are unique to Medicaid, if there is a potential access to care issue, and if rates are attributable to those issues. The Department will also further research reimbursement rates for ACF, adult day, and respite services to identify opportunities for improving service equity across waivers.

Conclusion

Analyses were inconclusive to determine if CMHS rates at 80.42% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[138]

The primary factors that led to this conclusion included:

- Small increases in utilizers and providers over time;
- A year-over-year decrease in distinct utilizers and active providers from CY 2018 to CY 2019; and
- Low rate benchmark comparisons for adult day, ACF, and respite services.

[138] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.

Elderly, Blind, and Disabled Waiver (EBD)

Service Description

The Elderly, Blind, and Disabled Waiver (EBD) service grouping, for the purposes of this report, is comprised of 14 procedure codes.[139] The EBD waiver provides a home or community-based alternative to nursing facility care for persons who are elderly, blind, or have a disability aged 18 and older. Services reviewed under the EBD Waiver include:[140]

- Adult Day Services
- Alternative Care Facility (ACF)
- Community Transitions
- Home Delivered Meals
- Homemaker
- IHSS Health Maintenance Activities
- IHSS Homemaker
- IHSS Personal Care
- Life Skills Training
- Non-Medical Transportation (NMT)
- Personal Care
- Respite

EBD Statistics	
Total Adjusted Expenditures CY 2019	$383,753,873
Total Members Utilizing Services in CY 2019	28,057
CY 2019 Over CY 2018 Change in Members Utilizing Services	(0.51%)
Total Active Providers CY 2019	857
CY 2019 Over CY 2018 Change in Active Providers	(1.27%)

Table 29. EBD expenditure and utilization data.

The EBD waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for EBD services are estimated at 95.22% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[141]

[139] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix B. For a complete list of procedure codes and services included in the EBD waiver, see the Health First Colorado Fee Schedule.
[140] A list of procedure codes included in each service grouping is contained in Appendix F.
[141] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

EBD Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$383,753,873	$403,026,633	**95.22%**

Table 30. Comparison of Colorado Medicaid EBD service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $19,272,760 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 14 procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[142] The individual rate ratios for EBD services were 38.29%-307.32%.[143] A summary of Colorado's expenditures described as a percentage relative to the expenditures of the other six states is presented below.

EBD Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	87.3%	85.7%	79.5%	102.5%	113.2%	102.0%

Table 31. Comparison of Colorado Medicaid EBD service payments to those of six other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's EBD service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

EBD Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Adult Day Services	$23,096,285	$27,218,393	**84.86%**
Alternative Care Facility (ACF)	$44,583,166	$60,956,389	**73.14%**
Community Transitions	$35,732	$42,062	**84.95%**
Home Delivered Meals	$109,922	$56,916	**193.13%**
Homemaker	$27,039,466	$23,352,913	**115.79%**
IHSS Health Maintenance Activities	$74,722,277	$89,971,081	**83.05%**
IHSS Homemaker	$14,489,154	$12,513,707	**115.79%**
IHSS Personal Care	$51,955,005	$49,182,100	**105.64%**
Life Skills Training	$125,716	$96,569	**130.18%**
Non-Medical Transportation (NMT)	$8,537,206	$7,858,602	**108.64%**
Personal Care	$137,812,578	$130,457,346	**105.64%**
Respite[144]	$1,247,369	$1,320,554	**94.46%**

Table 32. Comparison of Colorado Medicaid EBD service grouping payments to those of other payers, expressed as a percentage (CY 2019).[145]

[142] States used in the EBD rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah. For more details on the rate comparison methodology, see Appendix C.
[143] Individual rate ratios for each waiver by state and service grouping are contained in Appendix C.
[144] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[145] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for EBD services increased by 1.53% from an average of 27.55 utilizers per provider in CY 2018 to 27.97 utilizers per provider in CY 2019.[146] Additionally:

- In urban counties, panel size averaged 29.16 in CY 2018 and increased to 29.64 in CY 2019.
- In rural counties, panel size averaged 25.90 in CY 2018 and increased to 25.94 in CY 2019.
- In frontier counties, panel size averaged 17.31 in CY 2018 and increased to 17.92 in CY 2019.

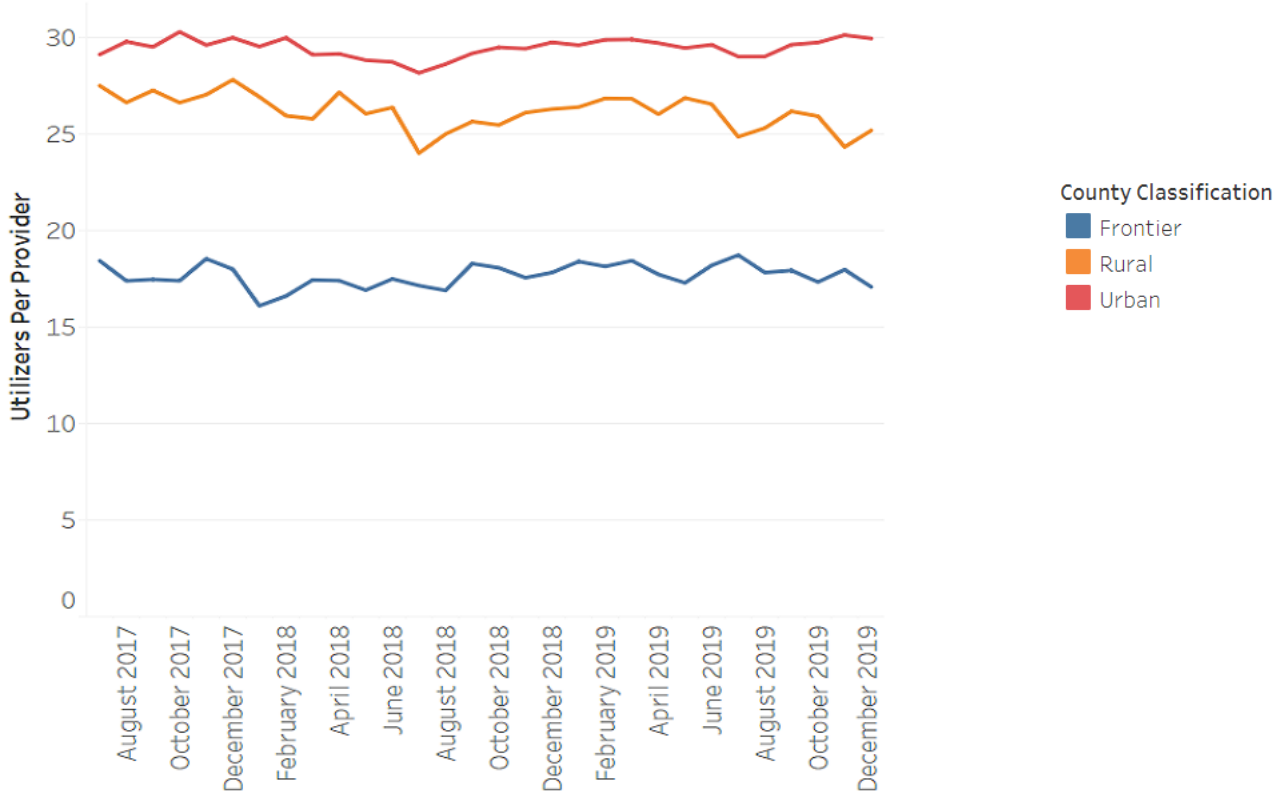

Figure 27. Utilizers per provider (panel size) for EBD services between July 2017 to December 2019.

Analysis indicates that there were increases in the number of distinct utilizers over this time across urban county classifications. Distinct utilizers remained relatively stable in rural counties, while active providers increased in those counties over this time. Both distinct utilizers and active providers remained relatively stable in frontier county classifications over this time.

The increase in distinct utilizers observed in urban counties, compared to the relatively steady number of active providers, led to a slight increase in panel size in those counties.[147] The increase in active providers observed in rural counties, compared to the relatively steady number of distinct utilizers, led to a slight decrease in panel size overall from July 2017 to December 2019 in those counties.

[146] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[147] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of EBD services reside throughout the state. Denver County had the highest number of utilizers at 4,662 in CY 2019.

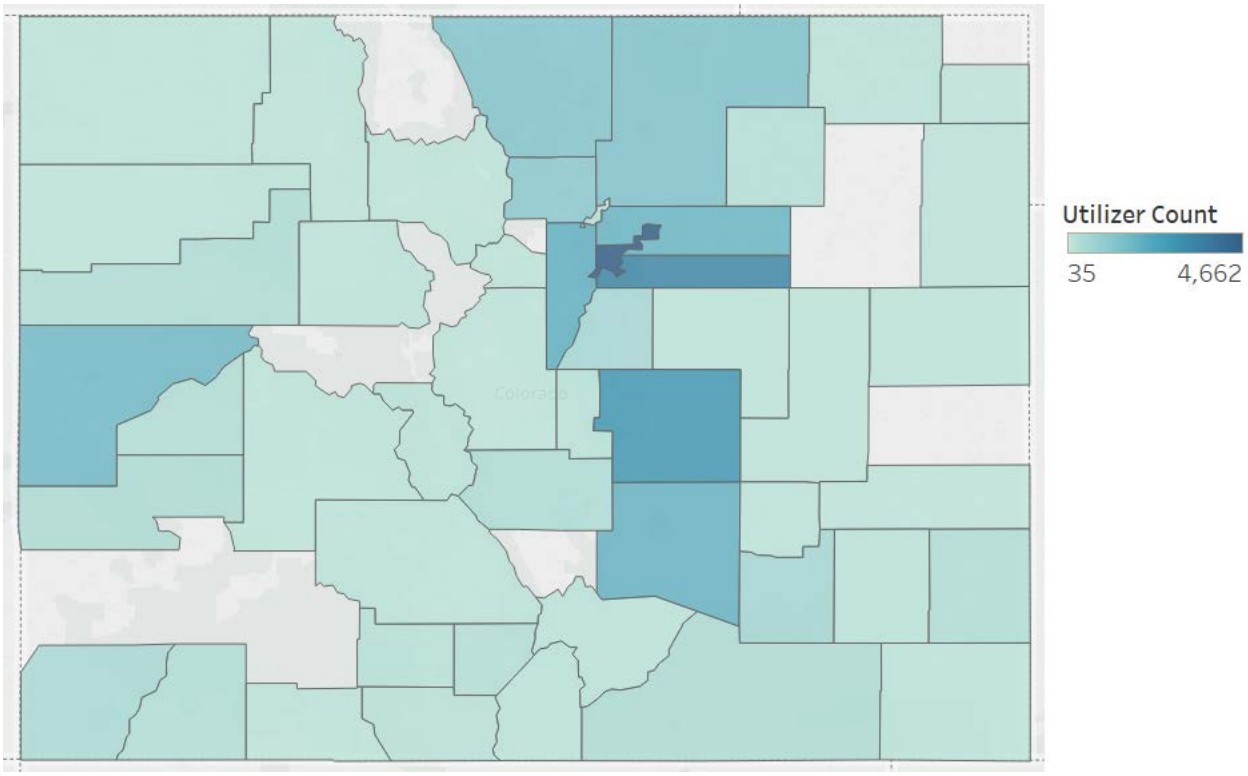

Figure 28. Utilizer density for EBD services by county for CY 2019.[148]

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

- relatively lower demand for EBD services, or a low number of Colorado Medicaid members utilizing EBD services.

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.

[148] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Kiowa County had the highest penetration rate at 84.66 in CY 2019.

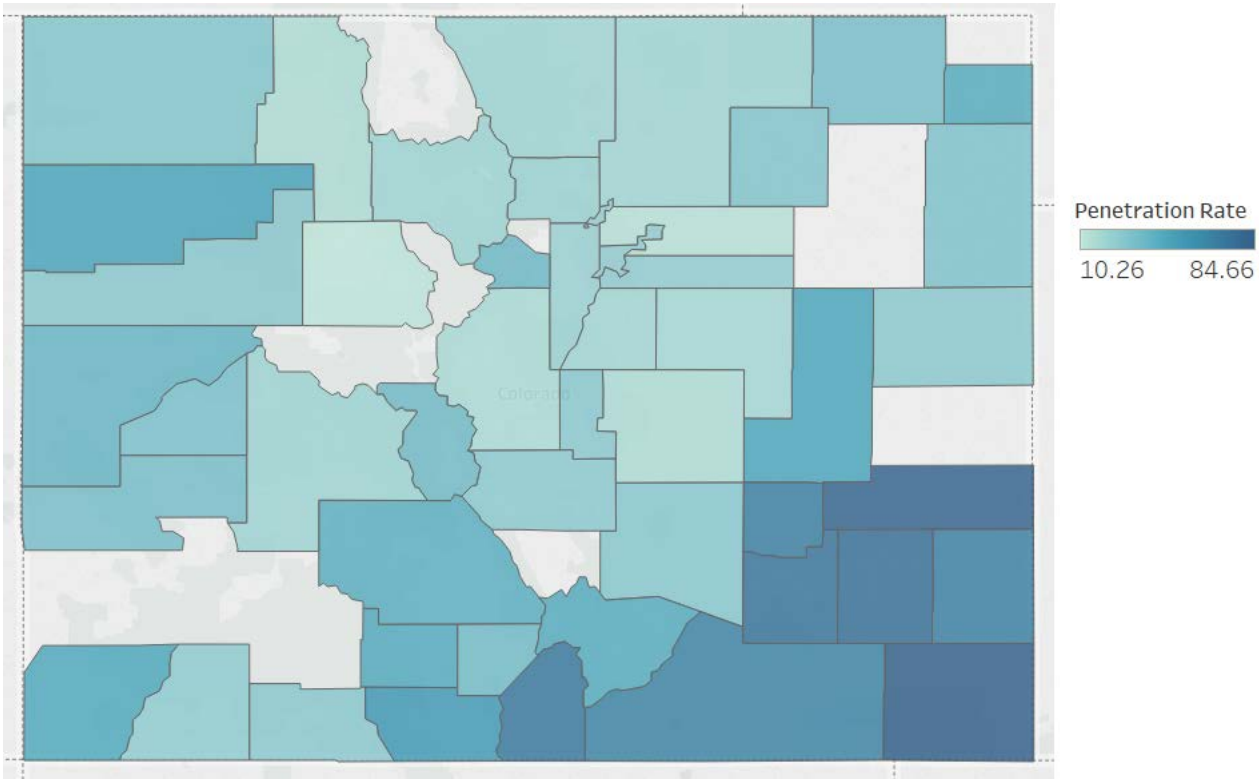

Figure 29. Penetration rates for EBD services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the EBD waiver is calculated as the total number of active EBD service providers per 1,000 members ages 18 and older.

EBD Member-to-Provider Ratios			
Region	**CY 2019 EBD Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 18+**	**Providers per 1,000 Members**
Frontier	113	28,365	3.99
Rural	206	102,729	2.01
Urban	750	755,426	0.99
Statewide	**857**	**886,520**	**0.97**

Table 33. Member-to-provider ratio for EBD services expressed as providers per 1,000 members by county classification in CY 2019. [149]

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.[150]

[149] Number of providers indicates provider agencies that have submitted claims, not individual providers or caregivers.
[150] Currently, the Department does not use member-to-provider ratio standards specific to EBD 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 total Colorado Medicaid members that live within certain drive time bands from where EBD services are provided.[151]

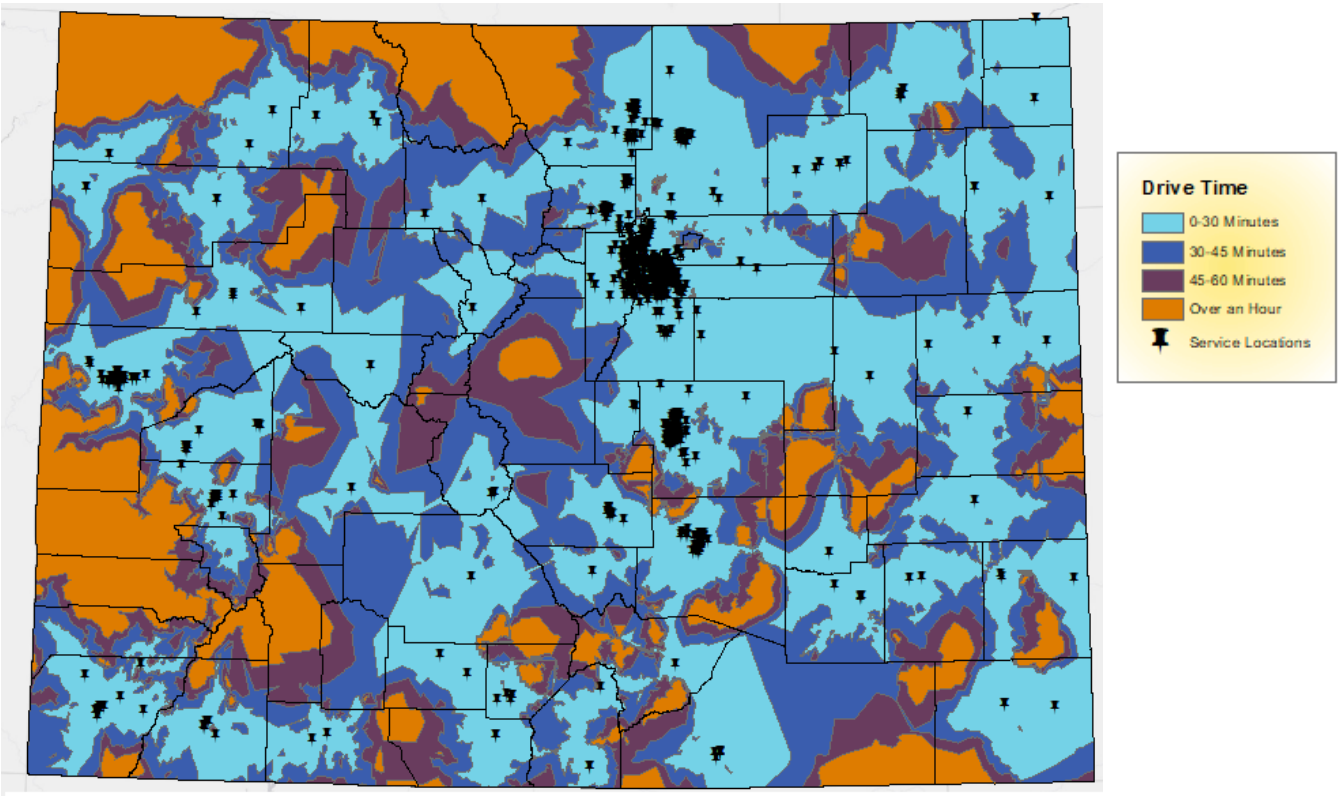

Figure 30. ArcGIS map of drive times of EBD service locations to total members in CY 2019.

Overall, 97.09% of the total Colorado Medicaid members in CY 2019 resided 30 minutes or less from an EBD provider. Additionally, 2.06% of total members resided approximately 30-45 minutes from an EBD provider; 0.46% of total members resided 45-60 minutes from an EBD provider. Finally, 0.38% of total members resided over an hour from an EBD provider.

[151] Due to claims data, service locations shown on the ArcGIS map represent provider billing locations. EBD services are provided in the member home and caregivers are not necessarily located where the service locations are shown on the map. Service locations represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[152] as well as stakeholder feedback received by Department staff, is summarized below.

- ACF per diem rates are much lower than other similar levels of assisted living facility-based care offered under Colorado Medicaid HCBS waivers (e.g., nursing facilities).
- Stakeholders expressed desire for number of hours for which in-home respite can be provider be increased; there is currently a 6.5-hour per day maximum for in-home respite services.
- Stakeholders also indicate that the pay structure for in-home respite services incentivizes facility-based care, such as in an ACF or nursing facility.
- Providers expressed concerns regarding current rates and the impact the minimum wage legislation pass-through will have on their ability to cover cost of service provision through Medicaid reimbursement alone.[153]
- Provider agencies of personal care services in rural areas expressed concerns regarding acquisition and retention of staff due to reportedly low reimbursement rates.
- Providers also expressed concern that access to services will be impacted by recent rules changes meant to enforce proper billing practices in regard to travel time reimbursement,[154] especially at the same time as the wage pass-through legislation placing a larger burden on provider agencies to pay adequate employee wages.

Additional Considerations

Other considerations include:

- EBD personal care and IHSS personal care services can be provided by a relative;
- Several reimbursement rates for EBD waiver services vary for the same or similar services provided on other waivers.[155]
- The Department is investigating the possibility of merging the CMHS waiver with the EBD waiver, but has identified challenges due to the increasing utilization and popularity of IHSS health maintenance activities;
    - in addition, EBD includes IHSS and in-home respite services that are currently not available to members enrolled on the CMHS waiver; merging these waivers is expected to increase expenditures for these services;
- All services available through the CMHS waiver are also available through the EBD waiver, but IHSS and in-home respite are not available to members enrolled in the CMHS waiver;
    - anecdotal evidence indicates members may be preferential to receiving services through the EBD waiver;

[152] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.
[153] This feedback refers to SB19-238, which was signed into law in 2019 with a wage pass-through for IHSS personal care and homemaker services.
[154] This change was based on CMS guidance.
[155] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.

- There has been an increase in total adjusted expenditures, distinct utilizers, and active providers since EBD waiver services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;
- ACF reimbursement rates received a 25% targeted rate increase (TRI), effective October 2018 as a result of the 2017 Medicaid Provider Rate Review Recommendation Report;[156]
- Some EBD services can be performed by family member;
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services;
- As of January 2021, the new Utilization Review/Utilization Management (UR/UM) contract with Telligen was initiated; this process includes a review of all Health Maintenance Activities (HMA) authorizations for appropriateness and to ensure there is no duplication of services.
- The total number of billing providers does not represent the total number of individual caregivers or service delivery providers employed by agencies providing EBD services; and
- Provider billing locations do not encompass all brick-and-mortar agency locations (e.g., the primary billing provider may also submit claims from auxiliary agency locations).

Additional Research

The Department plans to further investigate stakeholder comments regarding ACF, adult day, and respite service rates to identify opportunities for improving service equity across waivers.

Conclusion

Analyses were inconclusive to determine if EBD rates at 95.22% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[157]

The primary factors that led to this conclusion included:

- Distinct utilizers and active providers both decreased from CY 2018 to CY 2019;
- EBD waiver services have the highest member-to-provider ratio, indicating there are more providers available per 1,000 Medicaid members for these services than for other waiver services;
- Utilizers per provider (panel size) is increasing in urban counties, suggesting there is less provider capacity and thus utilizers may have difficulties accessing these services in those counties; and
- Rate comparison data shows Colorado reimbursement rates for EBD services are at least 80% of the benchmark in three states used in the comparison, and over 100% of the benchmark in three states.

[156] See the July 2018 Provider Bulletin for more information.
[157] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.

Waiver for Persons with Spinal Cord Injury (SCI)

Service Description

The Waiver for Persons with Spinal Cord Injury (SCI) service grouping, for the purposes of this report, is comprised of 11 procedure codes.[158] The SCI waiver provides a home or community-based alternative to nursing facility care for persons with a spinal cord injury aged 18 or older. SCI services are currently only available in the Denver metro area.[159] Service groupings reviewed under the SCI waiver include:[160]

- Adult Day Services
- Homemaker
- IHSS Health Maintenance Activities
- IHSS Homemaker
- IHSS Personal Care
- Non-Medical Transportation (NMT)
- Personal Care
- Complimentary & Integrative Health Services[161]
- Respite

SCI Statistics	
Total Adjusted Expenditures CY 2019	$3,454,973
Total Members Utilizing Services in CY 2019	264
CY 2019 Over CY 2018 Change in Members Utilizing Services	41.12%
Total Active Providers CY 2019	81
CY 2019 Over CY 2018 Change in Active Providers	19.12%

Table 34. SCI expenditure and utilization data.

The SCI waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for SCI services are estimated at 88.62% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[162]

SCI Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$3,454,973	$3,898,487	**88.62%**

Table 35. Comparison of Colorado Medicaid SCI service payments to those of other payers, expressed as a percentage (CY 2019).

[158] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the SCI waiver, see the Health First Colorado Fee Schedule.
[159] SCI services are only available to members residing in Adams, Arapahoe, Denver, Douglas, or Jefferson counties.
[160] A list of procedure codes included in each service grouping is contained in Appendix F.
[161] This service grouping includes acupuncture and chiropractic services, in addition to massage therapy. For more information on service groupings by waiver, see Appendix F.
[162] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

The estimated fiscal impact to Colorado Medicaid would be $443,514 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 11 procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[163] The individual rate ratios for SCI services were 57.08%-265.80%.[164] A summary of Colorado's expenditures described as a percentage relative to the expenditures of the other six states is presented below.

SCI Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	94.4%	93.0%	81.1%	92.1%	95.2%	84.1%

Table 36. Comparison of Colorado Medicaid SCI service payments to those of six other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's SCI service grouping expenditures described as a percentage relative to the average expenditures of six other states' Medicaid rates is presented below.

SCI Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Adult Day Services	$42,191	$40,624	**103.86%**
Homemaker	$129,797	$112,101	**115.79%**
IHSS Health Maintenance Activities	$2,183,034	$2,628,533	**83.05%**
IHSS Homemaker	$136,962	$118,289	**115.79%**
IHSS Personal Care	$185,542	$175,639	**105.64%**
Non-Medical Transportation (NMT)	$ 40,513	$23,595	**171.70%**
Personal Care	$323,312	$306,057	**105.64%**
Complimentary & Integrative Health Services	$403,725	$485,293	**83.19%**
Respite[165]	$9,894	$8,357	**118.39%**

Table 37. Comparison of Colorado Medicaid SCI service grouping payments to those of other payers, expressed as a percentage (CY 2019).[166]

[163] States used in the SCI rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[164] Individual rate ratios for each revenue code are contained in Appendix C.
[165] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[166] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for SCI services increased by 8.00% from an average of 2.80 utilizers per provider in CY 2018 to 3.02 utilizers per provider in CY 2019.[167] Additionally:

- In urban counties, panel size averaged 2.81 in CY 2018 and increased to 3.06 in CY 2019.

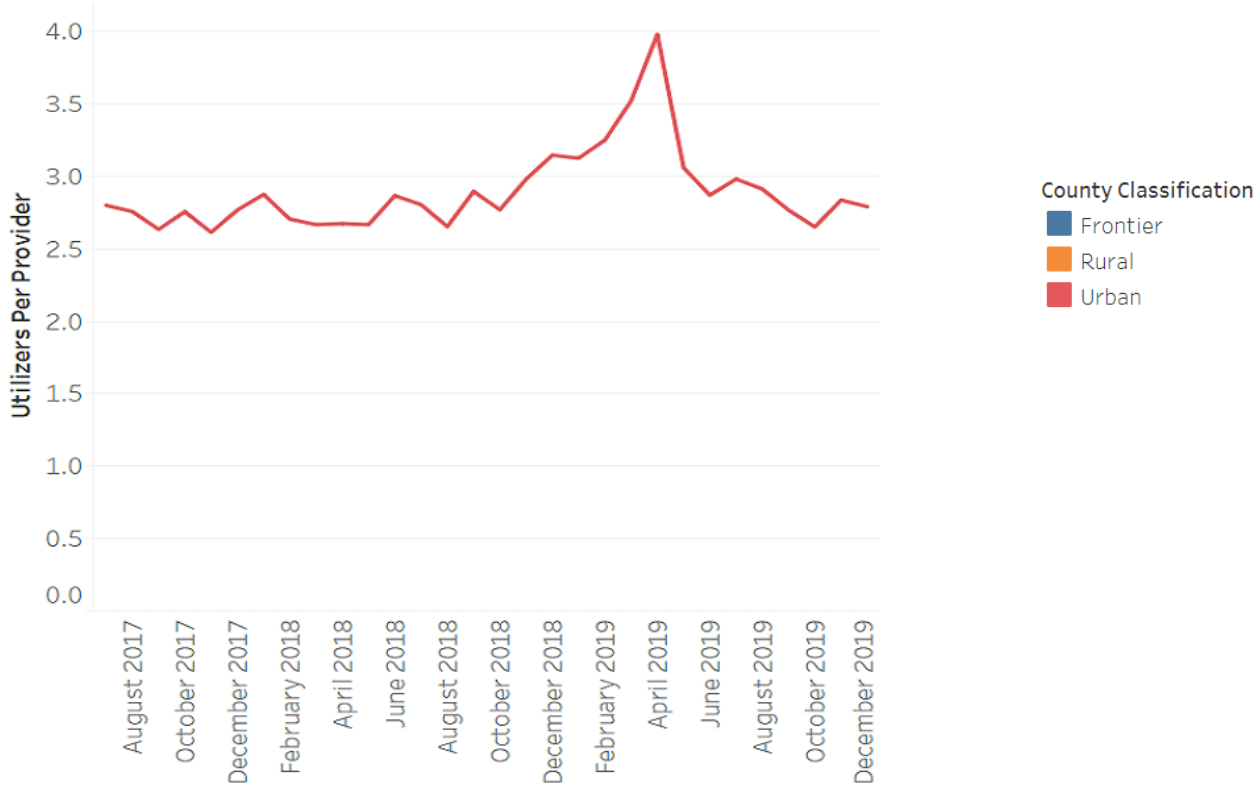

Figure 31. Utilizers per provider (panel size) for SCI services between July 2017 to December 2019. [168]

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across urban county classifications.

The increase in distinct utilizers observed in urban counties grew at a faster rate compared to the increase in active providers, which led to a slight increase in panel size in those counties.[169]

There was a noticeable change February 2019 to May 2019 that can be attributed to an increase in distinct utilizers resulting from a new location for SCI service providers that opened in January 2019, bringing more awareness to SCI services. This was followed shortly by an increase in active providers, which led to the decrease in panel size in April 2019.

[167] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[168] SCI services are only available to members residing in Adams, Arapahoe, Denver, Douglas, and Jefferson counties, accounting for the missing lines on the graph.
[169] For data specific to distinct utilizer and active providers, see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of SCI services reside throughout the state. Denver County had the highest number of utilizers at 73 in CY 2019.

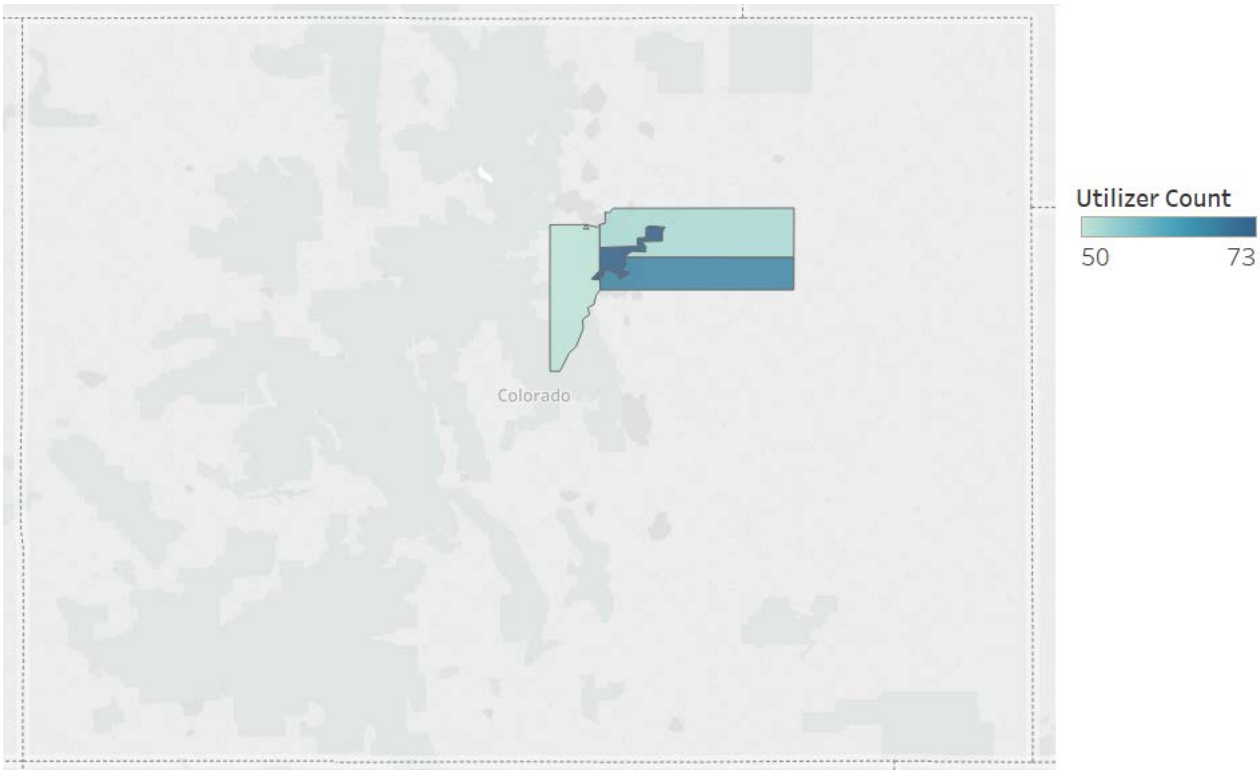

Figure 32. Utilizer density for SCI services by county for CY 2019.[170]

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

- relatively lower demand for SCI services, or a low number of Colorado Medicaid members utilizing SCI services.

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.[171]

[170] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.
[171] SCI services are only available to members residing in Adams, Arapahoe, Denver, Douglas, and Jefferson counties.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Jefferson County had the highest penetration rate at 0.56 in CY 2019.

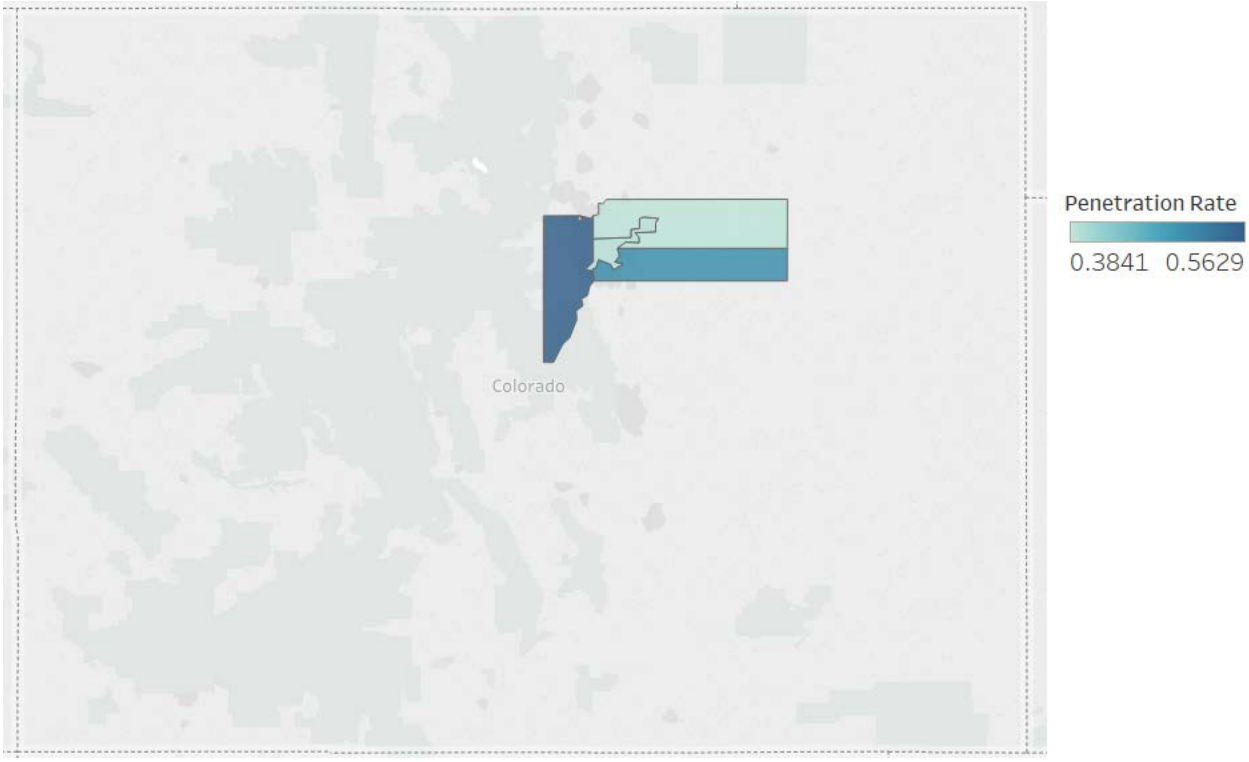

Figure 33. Penetration rates for SCI services by county in CY 2019.

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

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.[172]

[172] SCI services are only available to members residing in Adams, Arapahoe, Denver, Douglas, and Jefferson counties.

Member-to-Provider Ratios

The member-to-provider ratio for the SCI waiver is calculated as the total number of active SCI service providers per 1,000 members ages 18 and older.

SCI Member-to-Provider Ratios			
Region	**CY 2019 SCI Service Providers**[173]	**CY 2019 Total Colorado Medicaid Members Ages 18+**	**Providers per 1,000 Members**
Frontier	4	28,365	0.14
Rural	2	102,729	0.02
Urban	81	755,426	0.11
Statewide	**81**	**886,520**	**0.09**

Table 38. Member-to-provider ratio for SCI services expressed as providers per 1,000 members by county classification in CY 2019.

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 urban counties than there are in rural 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.[174]

[173] SCI waiver services are only available to members residing in the Denver Metro area (Adams, Denver, Arapahoe, Douglas, and Jefferson Counties), which is why the number of providers that have billing agencies in rural and/or frontier counties are limited. Total members were not limited to these counties due to PHI, as well as to gain insight on, and provide historical documentation for future review cycles for, statewide provider capacity if legislation passes a proposed bill to expand this waiver benefit to members statewide (see the SCI Additional Considerations section below).

[174] Currently, the Department does not use member-to-provider ratio standards specific to SCI 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 total Colorado Medicaid members that live within certain drive time bands from where SCI services are provided.[175]

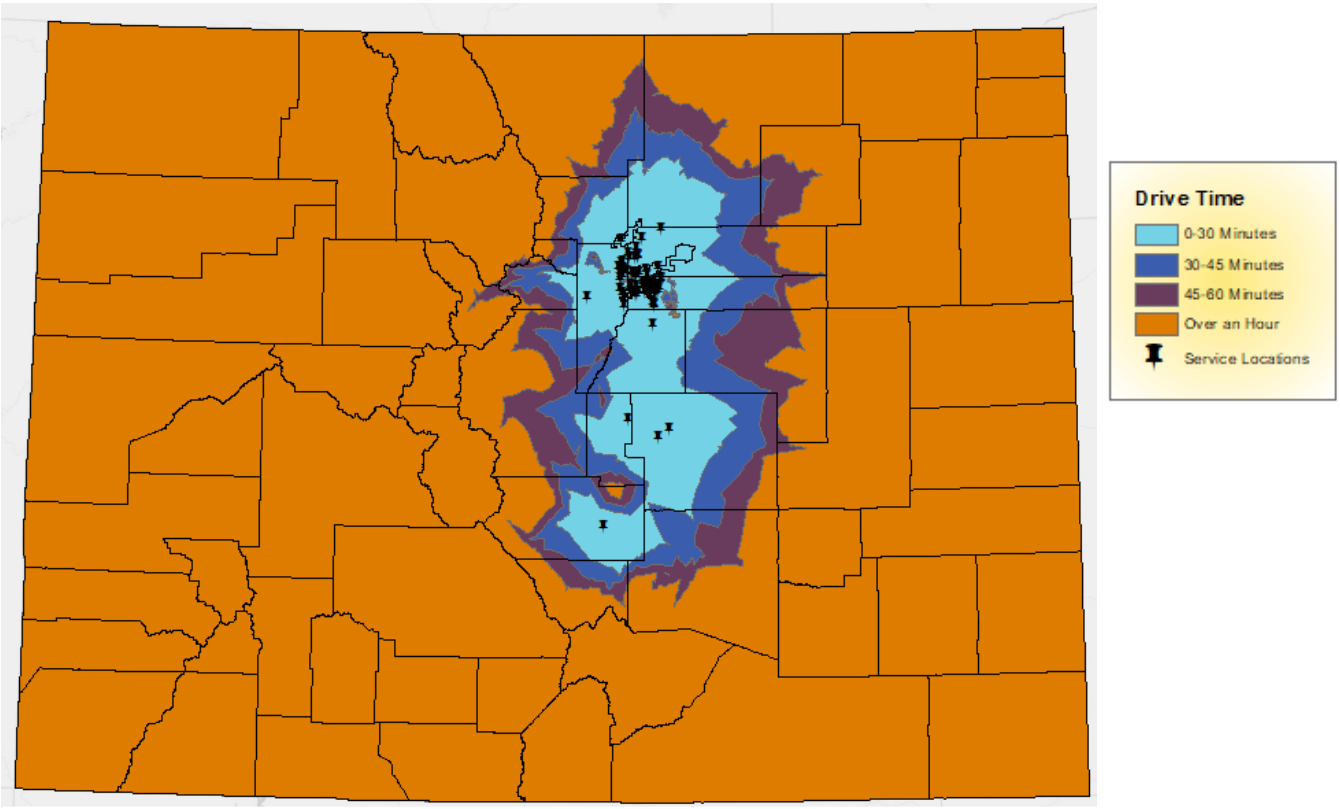

Figure 34. ArcGIS map of drive times of SCI service location to total members in CY 2019.[176]

Overall, 64.61% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a SCI provider. Additionally, 13.64% of total members resided approximately 30-45 minutes from a SCI provider; 5.37% of total members resided 45-60 minutes from a SCI provider. Finally, 16.38% of total members resided over an hour from a SCI provider.

[175] Due to claims data, service locations shown on the ArcGIS map represent service locations. SCI services are provided in home and community-based settings, and caregivers are not necessarily located where the service locations are shown on the map. Service locations represent providers that have submitted claims, not all auxiliary provider agencies or individual caregivers.

[176] SCI services are only available in the Denver metro area.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[177] as well as stakeholder feedback received by Department staff, is summarized below.

- There is a reported lack of providers Complementary & Integrative Health Services (i.e., professional therapy services including acupuncture, chiropractic, and massage therapy services on the SCI waiver) grouping on the SCI waiver.
- Stakeholders note that massage therapy services under the SCI waiver are reimbursed at a lower rate than massage therapy services reimbursed under other waivers.[178]

Additional Considerations

Other considerations include:

- There has been an increase in total adjusted expenditures, total utilizers, and providers rendering services since the SCI services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;
- The waitlist for SCI ended in July 2015, attributing to the increase in utilizers, providers, and expenditures;
- SCI services are only available to members in the Denver Metro area;
- There is currently legislation proposed to expand this waiver to members statewide; the Department is tracking this potential legislative change;
- SCI personal care and IHSS personal care services can be provided by a relative;
- Due to reportedly limited provider availability for complimentary and integrative health services, the Department prioritized direct provider outreach to providers of complimentary and integrative health services[179] since 2018 to increase enrollment of SCI providers;
- The Department continues to prioritize efforts to increase provider availability for SCI services;
- A new location for complementary and integrative health services[180] under the SCI waiver (included under professional therapy services for the purposes of this report) was opened in January of 2019, leading to an increase in both utilizers and providers of those services;
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services;
- The total number of billing providers does not represent the total number of individual caregivers employed by agencies providing SCI services; and
- Provider billing locations do not encompass all brick-and-mortar agency locations (e.g., the primary billing provider may also submit claims from auxiliary agency locations).

[177] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.
[178] For detailed HCBS waivers rate information, see the Health First Colorado Fee Schedule.
[179] Complementary & Integrative Health services include massage therapy, acupuncture, and chiropractic services; procedure-code level detail of services reviewed under each grouping is contained in Appendix F.
[180] Complimentary and integrative health services include massage therapy, acupuncture, and chiropractic services.

Additional Research

The Department plans to continue monitoring massage therapy, adult day, respite, and IHSS health maintenance activities across all waivers and investigate rate equity for similar services across waivers.

Conclusion

Analyses suggest SCI rates at 88.62% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- Waitlist for SCI services ended in 2015, increasing enrollment capacity;
- A year-over-year increase of 19.12% in active providers from CY 2018 to CY 2019;
- A year-over-year increase of 41.12% in distinct utilizers from CY 2018 to CY 2019;
- A new location opened in January 2019, increasing access to and demand for SCI services; and
- Legislation to provide SCI services statewide would increase access with the assistance of legislative support and resources.

Waiver for Children with Life Limiting Illness (CLLI)

Service Description

The Waiver for Children with Life Limiting Illness (CLLI) service grouping, for the purposes of this report, is comprised of 9 procedure codes.[181] The CLLI Waiver provides Colorado Medicaid benefits in the home for children with a life-limiting illness, from birth to age 18, and to allow the family to seek curative treatment while the child is receiving palliative or hospice care. The service groupings reviewed under the CLLI Waiver include:[182]

- Care Coordination
- Pain & Symptom Management
- Professional Therapy Services[183]
- Respite

CLLI Statistics	
Total Adjusted Expenditures CY 2019	$618,350
Total Members Utilizing Services in CY 2019	180
CY 2019 Over CY 2018 Change in Members Utilizing Services	(2.17%)
Total Active Providers CY 2019	13
CY 2019 Over CY 2018 Change in Active Providers	8.33%

Table 39. CLLI expenditure and utilization data.

The CLLI waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for CLLI services are estimated at 106.17% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[184]

CLLI Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$618,350	$582,429	**106.17%**

Table 40. Comparison of Colorado Medicaid CLLI service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $35,921 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 9 procedure codes analyzed in this service grouping were compared to an average of seven other states' Medicaid rates.[185] The CLLI individual rate ratios ranged from 58.42%-286.04%.[186] A summary of Colorado's

[181] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from July 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the CLLI waiver, see the Health First Colorado Fee Schedule.
[182] A list of procedure codes included in each service grouping is contained in Appendix F.
[183] A list of services included under the professional therapy services grouping is contained in Appendix F.
[184] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[185] States used in the CLLI rate comparison analysis were Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin. For more details on CLLI rate comparisons, see Appendix C.
[186] Individual rate ratios for each service grouping by state are contained in Appendix C.

expenditures described as a percentage relative to the expenditures of the other seven states is presented below.

CLLI Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates							
State	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	58.4%	84.6%	100.4%	286.0%	97.8%	64.6%	134.9%

Table 41. Comparison of Colorado Medicaid CLLI service payments to those of seven other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's CLLI service grouping expenditures described as a percentage relative to the average expenditures of seven other states' Medicaid rates is presented below.

CLLI Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Care Coordination[187]	$21,728	$31,085	**69.90%**
Pain & Symptom Management	$33,488	$23,645	**141.63%**
Professional Therapy Services	$516,660	$472,973	**109.24%**
Respite[188]	$46,474	$54,727	**84.92%**

Table 42. Comparison of Colorado Medicaid CLLI service grouping payments to those of other payers, expressed as a percentage (CY 2019).[189]

[187] Only one comparison rate was identified for care coordination services; the state used in the care coordination analysis was North Dakota. For more information, see the Care Coordination services analysis on page 124.
[188] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[189] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for CLLI services decreased by 7.02% from an average of 16.00 utilizers per provider in CY 2018 to 14.88 utilizers per provider in CY 2019.[190] Additionally:

- In urban counties, panel size averaged 25.00 in CY 2018 and decreased to 18.27 in CY 2019.

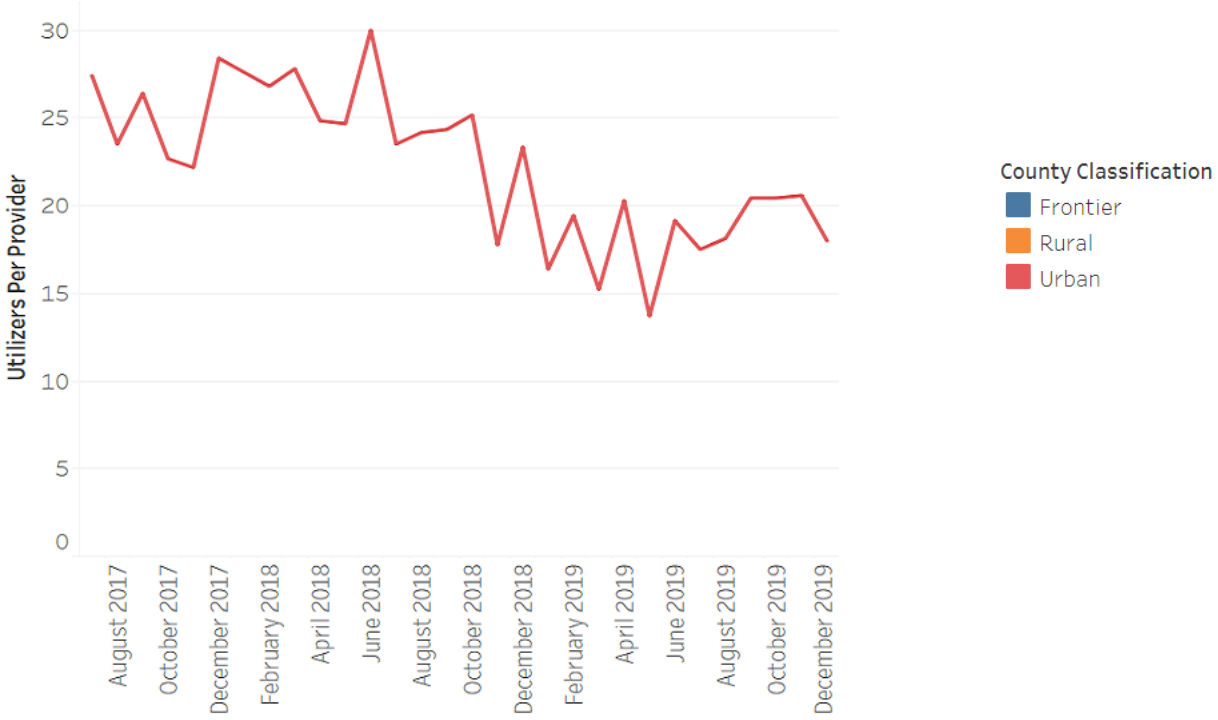

Figure 35. Utilizers per provider (panel size) for CLLI services between July 2017 to December 2019. [191]

Analysis indicates that there were increases in the number active providers over this time across urban county classifications.

The increase in the number of active providers in urban counties over this time, compared to the relatively stable number of distinct utilizers, led to a decrease in panel size in those counties.[192]

[190] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[191] Data from the frontier and rural county classification groups were blinded for protected health information (PHI), accounting for the missing line in the graph.
[192] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of CLLI services reside throughout the state. Denver County had the highest number of utilizers at 45 in CY 2019.

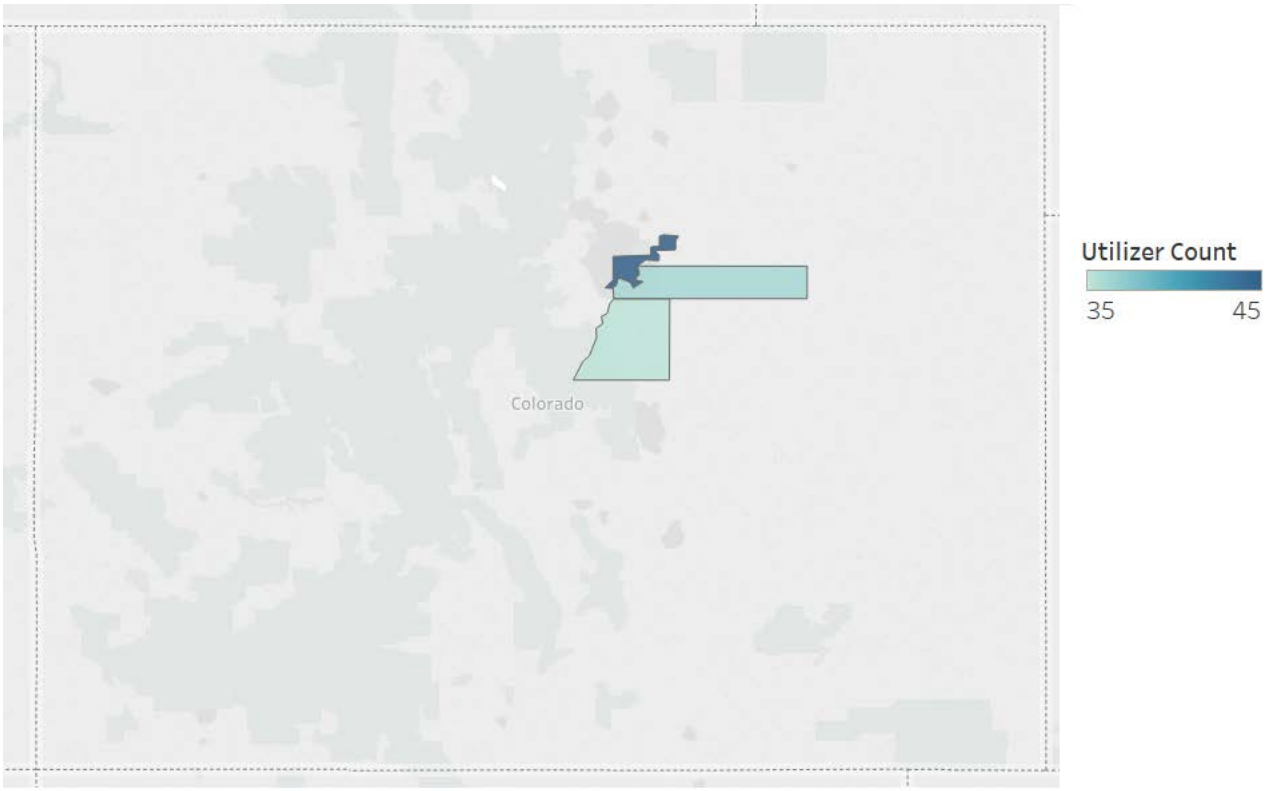

Figure 36. Utilizer density for CLLI services by county for CY 2019.[193]

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

- relatively lower demand for CLLI services, or a low number of Colorado Medicaid members utilizing CLLI services; and
- the CLLI benefit scope is relatively narrow.

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.

[193] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Douglas County had the highest penetration rate at 1.31 in CY 2019.

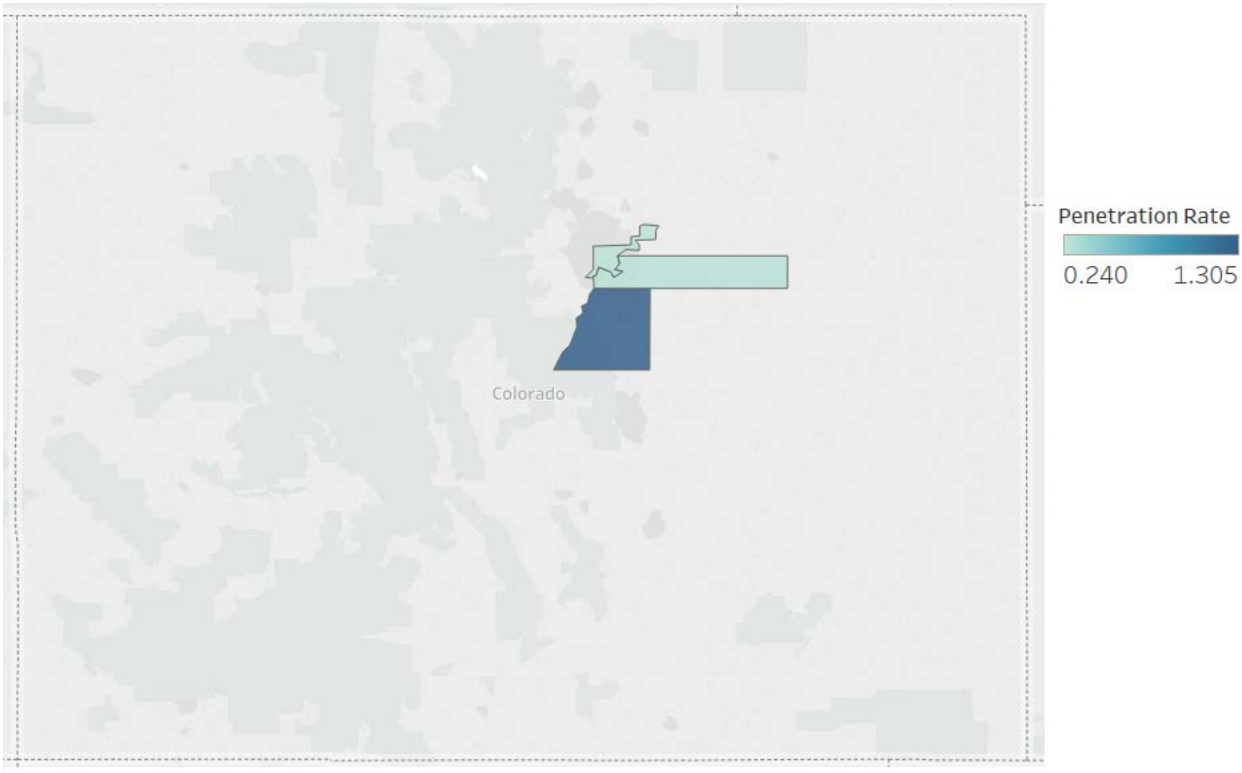

Figure 37. Penetration rates for CLLI services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the CLLI waiver is calculated as the total number of active CLLI service providers per 1,000 members ages 0-18.[194]

CLLI Member-to-Provider Ratios			
Region	**CY 2019 CLLI Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 0-18**	**Providers per 1,000 Members**
Frontier	0	17,025	NULL
Rural	4	67,595	0.05
Urban	12	541,874	0.02
Statewide	**13**	**626,753**	**0.02**

Table 43. Member-to-provider ratio for CLLI services expressed as providers per 1,000 members by county classification in CY 2019.

The member-to-provider ratio results indicate that there are less 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.[195]

[194] CLLI waiver services are available to recipients from birth through age 19; ages 0-18 is used in this analysis due to data limitations, which had a negligible effect on data results.

[195] Currently, the Department does not use member-to-provider ratio standards specific to CLLI 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 total Colorado Medicaid members that live within certain drive time bands from where CLLI services are provided.[196]

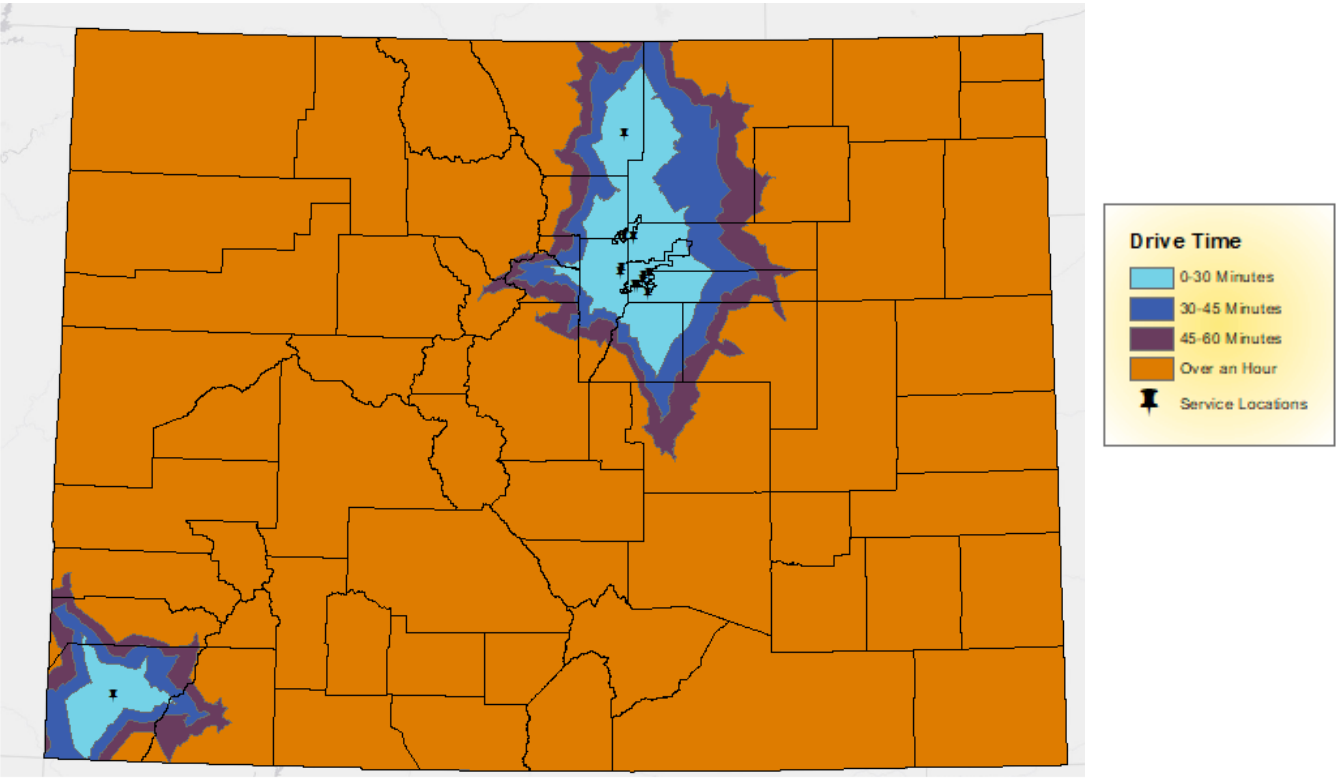

Figure 38. ArcGIS map of drive times of CLLI service location to total members in CY 2019.

Overall, 60.46% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a CLLI provider. Additionally, 3.41% of total members resided approximately 30-45 minutes from a CLLI provider; 12.24% of total members resided 45-60 minutes from a CLLI provider. Finally, 23.89% of total members resided over an hour from a CLLI provider.

[196] Due to claims data, service locations shown on the ArcGIS map represent provider billing locations. CLLI services are provided in the member home, as well as clinical settings, and caregivers are not necessarily located where the provider billing location is shown on the map. Service locations represent providers that have submitted claims, not all auxiliary CLLI agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[197] as well as stakeholder feedback received by Department staff, is summarized below.

- There is a reported lack of professional therapy services providers, particularly in rural and frontier counties; some feedback indicates that rates are too low for provider retention in counties where utilization is so low, which creates access issues for the members who do need CLLI services in those counties.

Additional Considerations

Other considerations included:

- The Department has started allowing reimbursement for HCBS telehealth services and is working to implement HCBS telehealth services permanently, which is expected to increase access;[198]
- The Butterfly Program, a provider of several CLLI services, closed in late 2018, which led to a slight decrease in utilization; however, increases in active providers during this time indicate members' access to CLLI services was not significantly impacted by this closure; the Department will continue to monitor access to these services and whether decrease in active providers for palliative and supportive care services is a result of low need for these services or if an access issue may be present, if it is unique to Medicaid, and whether it is attributable to rates.
- The Department continues to prioritize efforts to increase provider availability for CLLI services, especially rural and frontier counties (including the Front Range); and
- The CLLI waiver has typically low utilization due to the nature of the population this waiver serves; low demand for services often results in lower numbers of providers rendering those services.

Additional Research

The Department will continue to monitor utilization and further investigate if low utilization in rural and frontier counties is due to low need for CLLI services or if it is because there are no providers available to provide CLLI services in those counties.

Conclusion

Analyses were inconclusive to determine if CLLI rates at 106.17% of the benchmark were sufficient for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[199]

The primary factors that led to this conclusion included:

[197] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.
[198] The Department was approved to provide HCBS telehealth services by CMS for the duration of the COVID-19 pandemic, and is investigating the possibility of implementing permanent HCBS telehealth services. More information on the status of HCBS telehealth services can be found on the Office of Community Living (OCL) Stakeholder Engagement web page.
[199] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.

- Increase in providers over time, even as utilization decreased; and
- The lower number of active providers likely results from low demand for services and does not indicate an access or rate issue.

Children's Extensive Supports Waiver (CES)

Service Description

The Children's Extensive Supports Waiver (CES) service grouping, for the purposes of this report, is comprised of 7 procedure codes.[200] The CES Waiver provides Colorado Medicaid benefits in the home for children from birth through age 17 with developmental disabilities or delays who are most in need due to the severity of their disability. Service groupings reviewed under the CES Waiver include:[201]

- Community Connector
- Homemaker
- Professional Therapy Services
- Respite

CES Statistics	
Total Adjusted Expenditures CY 2019	$23,889,168
Total Members Utilizing Services in CY 2019	2,199
CY 2019 Over CY 2018 Change in Members Utilizing Services	10.45%
Total Active Providers CY 2019	183
CY 2019 Over CY 2018 Change in Active Providers	2.81%

Table 44. CES expenditure and utilization data.

The CES waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for CES services are estimated at 131.11% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[202]

CES Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$23,889,168	$18,221,035	**131.11%**

Table 45. Comparison of Colorado Medicaid CES service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $5,668,133 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 7 procedure codes and modifier combinations analyzed in this service grouping were compared to an average of seven other states' Medicaid rates.[203] The CES individual rate ratios ranged from 63.90%-292.62%.[204] A summary

[200] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the CES waiver, see the Health First Colorado Fee Schedule.
[201] A list of procedure codes included in each service grouping is contained in Appendix F.
[202] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[203] States used in the CES rate comparison analysis were Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin. For more details on CES rate comparisons, see Appendix C.
[204] Individual rate ratios for each service grouping by state are contained in Appendix C.

of Colorado's expenditures described as a percentage relative to the expenditures of the other seven states is presented below.

CES Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates							
State	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	68.2%	105.2%	121.2%	211.1%	148.9%	97.4%	126.1%

Table 46. Comparison of Colorado Medicaid CES service payments to those of seven other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's CES service grouping expenditures described as a percentage relative to the average expenditures of seven other states' Medicaid rates is presented below.

CES Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Community Connector[205]	$6,467,423	$2,530,937	**255.53%**
Homemaker	$ 3,528,952	$2,522,170	**139.92%**
Professional Therapy Services	$4,284,289	$4,035,425	**106.17%**
Respite[206]	$9,608,504	$9,132,503	**105.21%**

Table 47. Comparison of Colorado Medicaid CES service grouping payments to those of other payers, expressed as a percentage (CY 2019).[207]

[205] The Department identified only one comparable rate for community connector services (Ohio). For more details on CES rate comparison methodology, see Appendix C. More information is also presented in the Community Connector service grouping analysis on page 124.
[206] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[207] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, the average panel size for CES services increased from an average of 10.74 utilizers per provider in CY 2018 to 10.90 in CY 2019.[208] Additionally:

- In urban counties, panel size averaged 12.33 in CY 2018 and decreased to 12.12 in CY 2019.
- In rural counties, panel size averaged 2.01 in CY 2018 and increased to 2.65 in CY 2019.

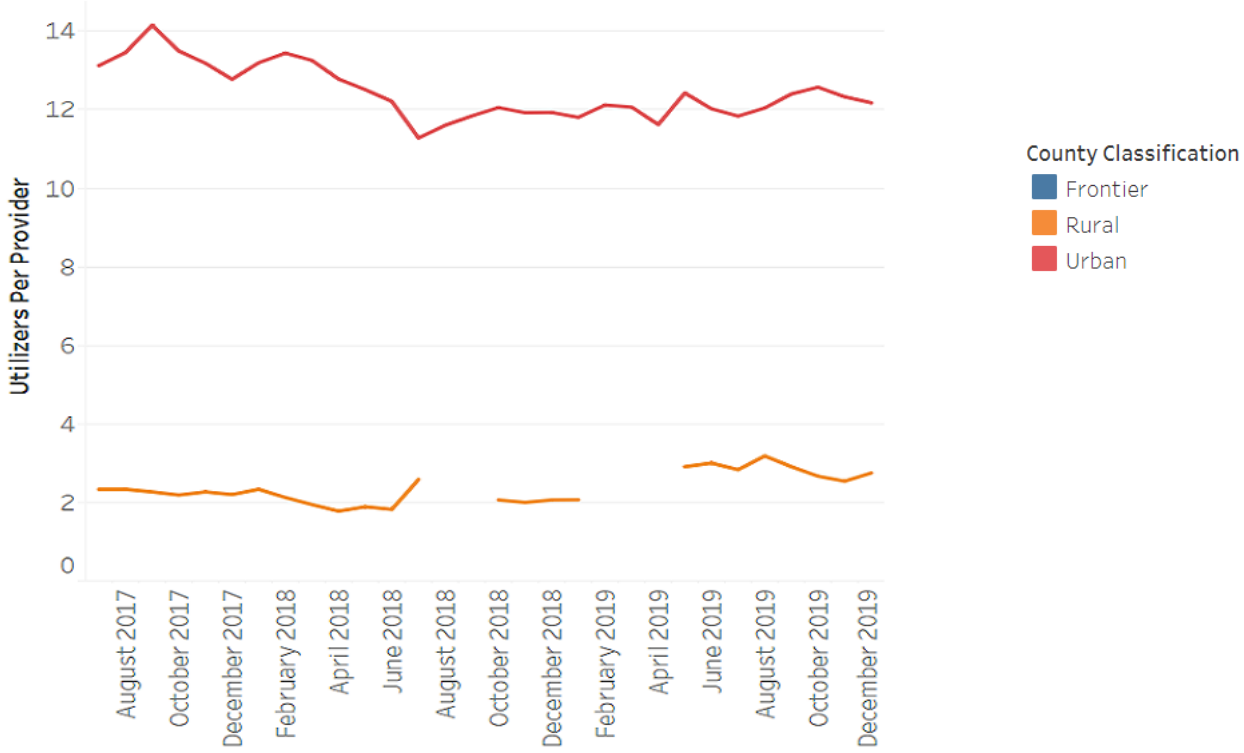

Figure 39. Utilizers per provider (panel size) for CES services between July 2017 to December 2019.[209]

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across urban county classifications. In addition, active providers increased over this time in frontier counties.[210]

The number of active providers in urban counties increased at a greater rate than the number of distinct utilizers over time, which led to an overall decrease in the average panel size in those counties. The decrease in active providers over this time in rural counties, compared to the relatively steady number of distinct utilizers, led to a slight increase in panel size in these counties.

[208] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[209] Data from the frontier and rural classification groups were blinded for protected health information (PHI), accounting for the missing line and gaps in the graph.
[210] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of CES services reside throughout the state. El Paso County had the highest number of utilizers at 484 in CY 2019.

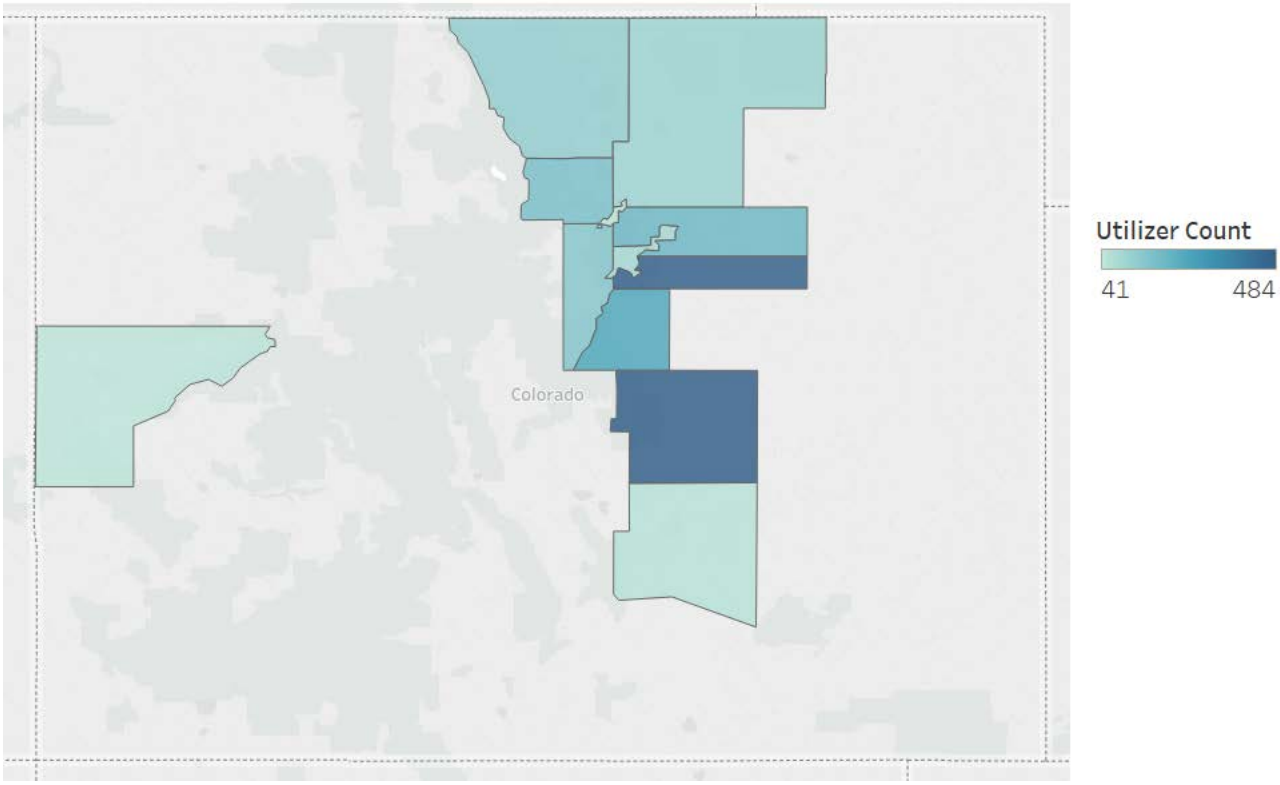

Figure 40. Utilizer density for CES services by county for CY 2019.[211]

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

- relatively lower demand for CES services, or a low number of Colorado Medicaid members utilizing CES services.

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.

[211] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Douglas County had the highest penetration rate at 9.43 in CY 2019.

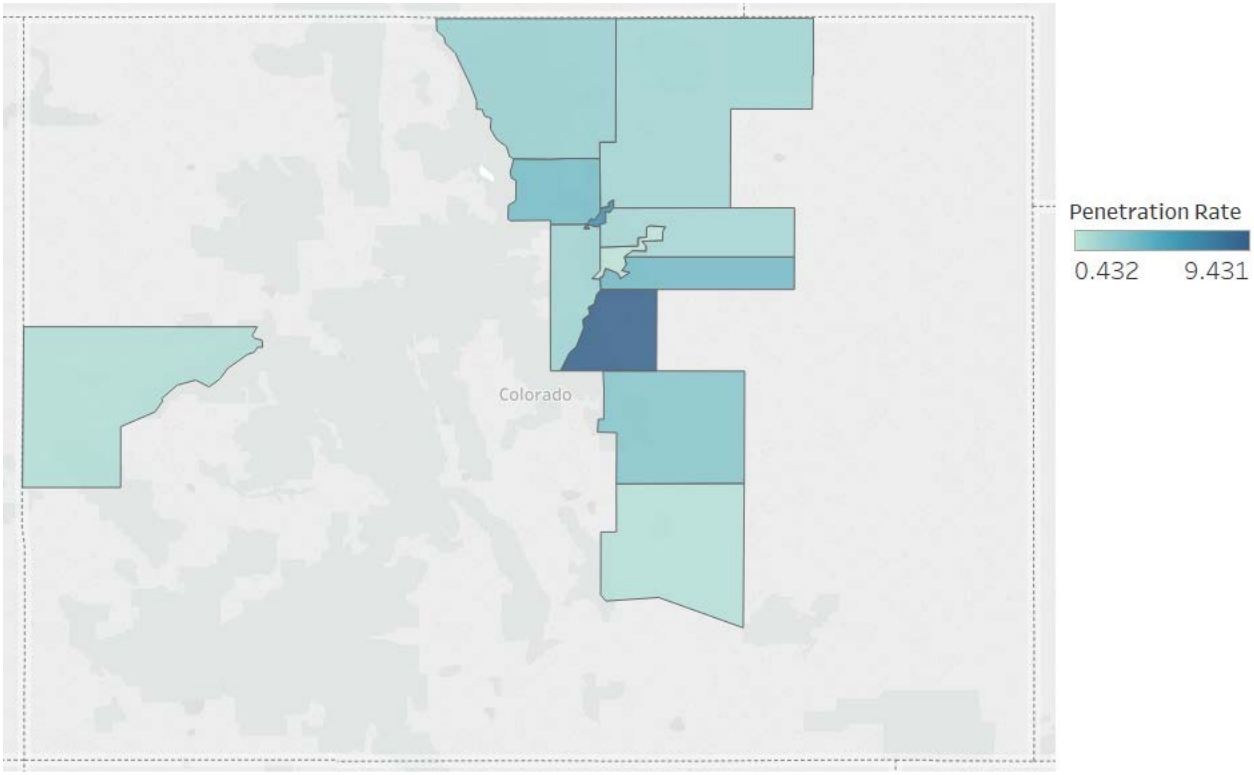

Figure 41. Penetration rates for CES services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the CES waiver is calculated as the total number of active CES service providers per 1,000 members ages 0-18.[212]

CES Member-to-Provider Ratios			
Region	**CY 2019 CES Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 0-18**	**Providers per 1,000 Members**
Frontier	11	17,025	0.65
Rural	20	67,595	0.30
Urban	172	541,874	0.32
Statewide	**183**	**626,753**	**0.29**

Table 48. Member-to-provider ratio for CES services expressed as providers per 1,000 members by county classification in CY 2019.

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 urban counties than there are in rural counties.[213] The Department will investigate providers in rural counties to identify if the lower member-to-provider ratio in rural counties is leading to an access issue in those counties, whether or not it is unique to Medicaid, and if they are attributable to rates.

[212] CES waiver services are only available to recipients from birth through age 17; ages 0-18 is used in this analysis due to data limitations, which had a negligible effect on data results.

[213] Currently, the Department does not use member-to-provider ratio standards specific to CES 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 total Colorado Medicaid members that live within certain drive time bands from where CES services are provided.[214]

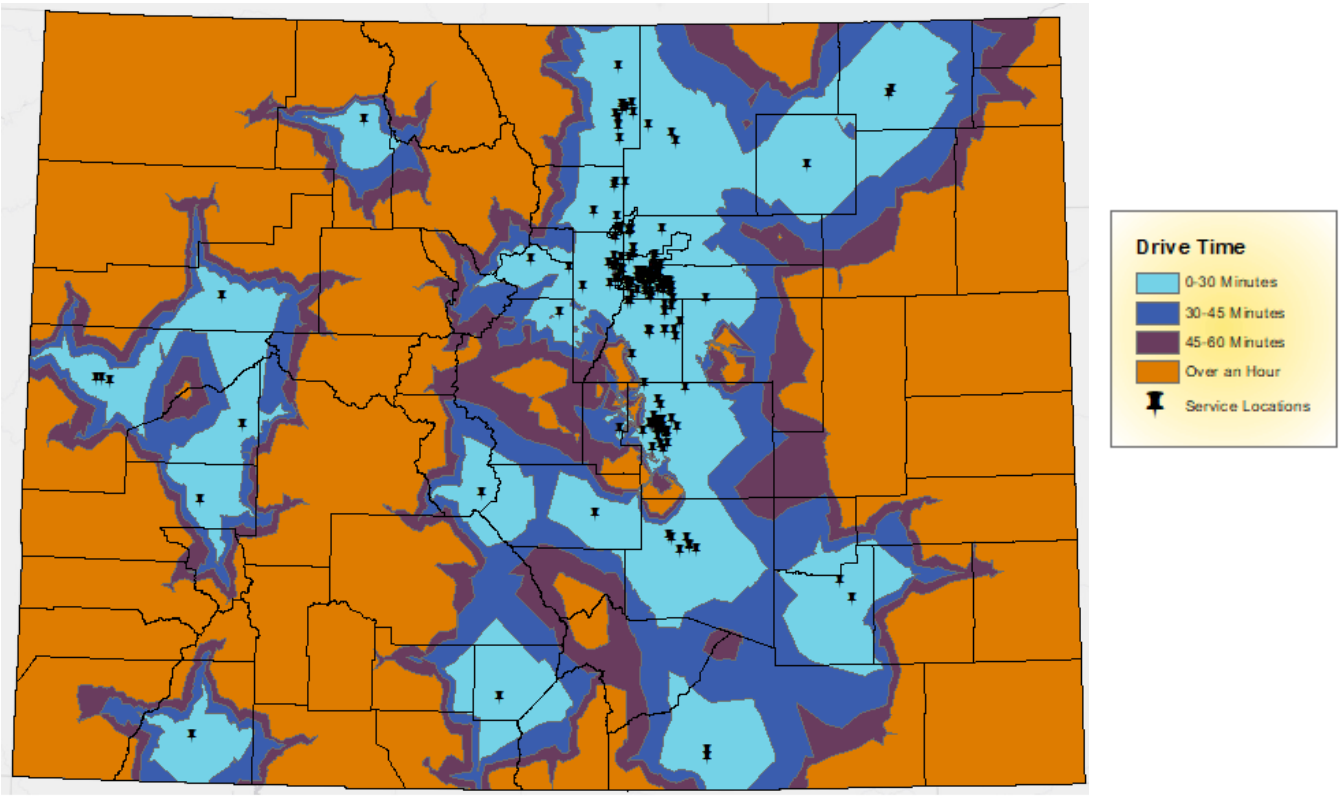

Figure 42. ArcGIS map of drive times of CES service locations to total members in CY 2019.

Overall, 92.50% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a CES provider. Additionally, 2.35% of total members resided approximately 30-45 minutes from a CES provider; 2.11% of total members resided 45-60 minutes from a CES provider. Finally, 3.03% of total members resided over an hour from a CES provider.

[214] Due to claims data, service locations shown on the ArcGIS map represent provider billing locations. CES services are provided in the member home, as well as clinical settings, and caregivers are not necessarily located where the provider billing location is shown on the map. Service locations represent providers that have submitted claims, not all auxiliary CES agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[215] as well as stakeholder feedback received by Department staff, is summarized below.

- Provider agencies of homemaker services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.
- There is a reported lack of professional therapy services providers, particularly in rural and frontier counties; some feedback indicates that rates are too low for provider retention in counties where utilization is so low, which creates access issues for the members who do need CES services in those counties. This is particularly notable for hippotherapy service providers.
- There is a reportedly low number of respite providers available for members enrolled in the CES waiver.

Additional Considerations

Other considerations included:

- The Department is engaged in continual attempts to increase provider availability in rural and frontier counties;
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS services), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services; and
- Personal care services were removed from the CES waiver in 2015 and are now available to Colorado Medicaid members ages 0-20 through pediatric personal care services now offered as a State Plan benefit.[216]

Additional Research

The Department plans to further investigate stakeholder feedback regarding homemaker, respite, and professional therapy services rates and their impact on access to care and provider retention, if any.

Conclusion

Analyses suggest CES rates at 131.11% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- Increases continue in both active utilizers and distinct utilizers after the waitlist for CES enrollment ended shortly before the previous review cycle; and
- Rate comparison data shows individual rate ratios for all CES services are above 100% of the benchmark, ranging from 105.21% to 255.53%.

[215] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.
[216] Pediatric personal care services were reviewed in the 2020 Medicaid Provider Rate Review Analysis Report.

Children's Habilitative Residential Waiver (CHRP)

Service Description

The Children's Habilitative Residential Waiver (CHRP) service grouping, for the purposes of this report, is comprised of five procedure codes.[217] The CHRP Waiver provides services for children and youth, from birth through age 20, who have a developmental disability and extraordinary needs that put them at risk of, or in need of, out-if-home placement. Service groupings reviewed under the CHRP Waiver include:[218]

- Foster Home
- Group Home
- Professional Therapy Services[219]
- Respite

CHRP Statistics	
Total Adjusted Expenditures CY 2019	$1,539,286
Total Members Utilizing Services in CY 2019	44
CY 2019 Over CY 2018 Change in Members Utilizing Services	2.33%
Total Rendering Providers CY 2019	18
CY 2019 Over CY 2018 Change in Rendering Providers	(10.00%)

Table 49. CHRP expenditure and utilization data.

The CHRP waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for CHRP services are estimated at 129.38% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[220]

CHRP Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$1,539,286	$1,189,780	**129.38%**

Table 50. Comparison of Colorado Medicaid CHRP service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $349,506 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 5 procedure codes and modifier combinations analyzed in this service grouping were compared to an average of seven other

[217] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the CHRP waiver, see the Health First Colorado Fee Schedule.
[218] A list of procedure codes included in each service grouping is contained in Appendix F.
[219] Professional therapy services under the CHRP waiver include massage therapy, movement therapy, and hippotherapy. More details regarding procedure codes included in each services grouping are contained in Appendix F.
[220] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

states' Medicaid rates.[221] The CHRP individual rate ratios ranged from 63.33%-307.81%.[222] A summary of Colorado's expenditures described as a percentage relative to the expenditures of the other seven states is presented below.

CHRP Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates							
State	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	68.2%	105.2%	121.2%	211.1%	148.9%	97.4%	126.1%

Table 51. Comparison of Colorado Medicaid CHRP service payments to those of seven other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's CHRP service grouping expenditures described as a percentage relative to the average expenditures of seven other states' Medicaid rates is presented below.

CHRP Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Foster Home	$1,368,229	$1,024,389	**133.57%**
Group Home	$165,920	$162,134	**102.33%**
Professional Therapy Services	$1,221	$1,113	**109.71%**
Respite[223]	$3,916	$2,143	**182.69%**

Table 52. Comparison of Colorado Medicaid CHRP service grouping payments to those of other payers, expressed as a percentage (CY 2019).[224]

[221] States used in the CHRP rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, Utah, and Wisconsin. For more details on CHRP rate comparisons, see Appendix C.
[222] Individual rate ratios for each service grouping by state are contained in Appendix C.
[223] Respite is offered in multiple settings and can vary across waivers; for more information on waiver-specific rates, see the Health First Colorado Fee Schedule.
[224] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for CHRP services increased by 8.12% from CY 2018 to CY 2019.[225] Additionally:

- In urban counties, panel size increased by 8.61% from CY 2018 to CY 2019.
- In rural counties, panel size increased by 33.33% from CY 2018 to CY 2019.

Analyses suggest that there was a decrease in providers in urban counties from July 2017 to September 2019,[226] with an increase in providers indicated from September 2019 through December 2019.[227]

The overall decrease in providers in urban counties over this time, compared to the increase in utilizers, led to an increase in panel size in those counties over this time.

Prior to July 1, 2019, the waiver eligibility criteria for CHRP was limited to children/youth who were in foster care. That requirement was removed July 1, 2019, which opened CHRP services to children not in child welfare. In addition, the waiver benefits were amended to provide the ability for children to stay in the family home to receive services other than habilitation. The result of these policy changes is a dramatic increase in enrollments on the CHRP Waiver since July 1, 2019. There were significant increases in both providers and utilizers toward the end of CY 2019 as more members learned of the changes in eligibility, and as Community Center Boards (CCBs) gained a greater understanding of the changes and began enrolling more members.

[225] Data from the urban, rural, and frontier classification groups were blinded for protected health information (PHI), accounting for the omitted panel size line graph.
[226] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[227] For data specific to active providers, see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of CHRP services reside throughout the state. The CHRP utilizer density heat map has been omitted due to protected health information (PHI). For these services, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. The CHRP penetration rate heat map has been omitted due to protected health information (PHI). For these services, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Member-to-Provider Ratios

The member-to-provider ratio for the CHRP waiver is calculated as the total number of active CHRP service providers per 1,000 members ages 0-20.

CHRP Member-to-Provider Ratios			
Region	**CY 2019 CHRP Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 0-20**	**Providers per 1,000 Members**
Frontier	0	19,845	NULL
Rural	1	77,200	0.01
Urban	18	601,684	0.03
Statewide	**18**	**698,729**	**0.03**

Table 53. Member-to-provider ratio for CHRP services expressed as providers per 1,000 members by county classification in CY 2019.

The member-to-provider ratio results indicate that there more providers per 1,000 members in urban counties than there are in rural counties.[228] The Department will investigate providers in rural counties to identify if the lower member-to-provider ratio in rural counties is leading to an access issue in those counties, whether or not it is unique to Medicaid, and if they are attributable to rates.

[228] Currently, the Department does not use member-to-provider ratio standards specific to CHRP 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 total Colorado Medicaid members that live within certain drive time bands from where CHRP services are provided.[229]

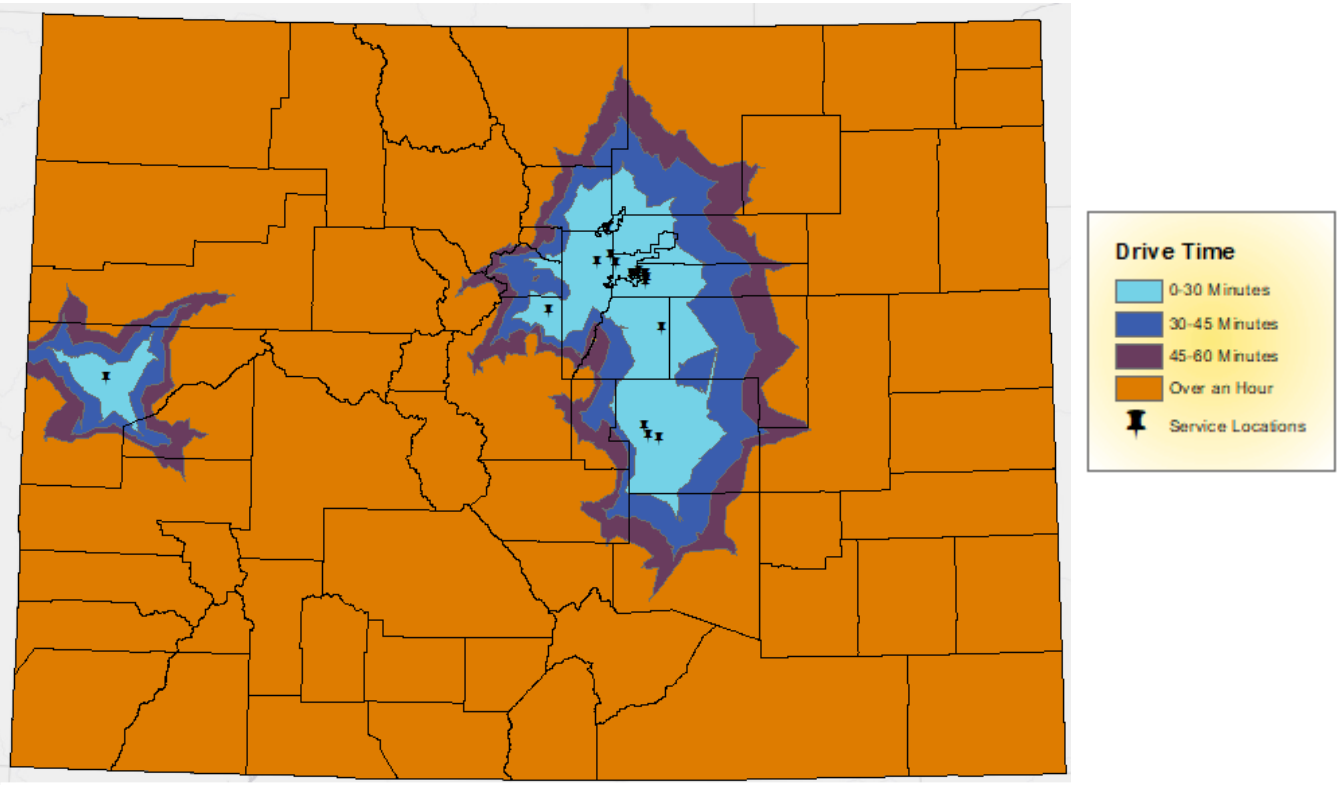

Figure 43. ArcGIS map of drive times of CHRP service locations to total members in CY 2019.

Overall, 69.90% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a CHRP provider. Additionally, 7.39% of total members resided approximately 30-45 minutes from a CHRP provider; 10.39% of total members resided 45-60 minutes from a CHRP provider. Finally, 12.90% of total members resided over an hour from a CHRP provider.

[229] Due to claims data, service locations shown on the ArcGIS map represent provider billing locations. CHRP services are provided in the member home, as well as clinical settings, and caregivers are not necessarily located where the provider billing location is shown on the map. Service locations represent providers that have submitted claims, not all auxiliary CHRP agencies or individual caregivers.

Stakeholder Feedback

Themes that emerged from stakeholder and committee member comments during the Medicaid Provider Rate Review public meeting on February 5, 2021,[230] as well as stakeholder feedback received by Department staff, is summarized below.

- There is a reported lack of professional therapy services providers, particularly in rural and frontier counties; some feedback indicates that rates are too low for provider retention in counties where utilization is so low, which creates access issues for the members who do need professional therapy services in those counties.

Additional Considerations

Other considerations included:

- In January 2018, behavioral therapy services were removed from this particular waiver and implemented as a benefit through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; this change has increased provider availability and member access to pediatric behavioral therapy services since 2018 and the Department is currently seeking federal approval to make pediatric behavioral therapy services a State Plan benefit;
- In January 2019, the requirement that limited eligibility and enrollment on the CHRP waiver to foster care or child welfare recipients was removed, allowing children to stay in the family home to receive services available through the CHRP waiver.
- Increases in utilization and active providers continued after January 2019 eligibility change once Community Center Boards (CCBs) gained a greater understanding of the changes and began enrolling more members and providers.

Additional Research

The Department plans to further investigate stakeholder feedback regarding professional therapy services rates and their impact on access to care and provider retention, if any.

Conclusion

Analyses suggest CHRP rates at 129.38% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- Significant increase in distinct utilizers and active providers over time; and
- Rate comparison data shows individual rate ratios for all CHRP services are above 100% of the benchmark, ranging from 102.33%-182.69%.

[230] The meeting recording for the Medicaid Provider Rate Review Process public meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review web page.

Children's Home and Community Based Waivers (CHCBS)

Service Description

The Children's Home and Community Based Waiver (CHCBS) service grouping, for the purposes of this report, is comprised of two procedure codes.[231] The CHCBS Waiver provides Colorado Medicaid benefits in the home or community for children, from birth through age 17, with disabilities who would otherwise be ineligible for Colorado Medicaid due to excess parental income and/or resources. Service groupings reviewed under the CHCBS Waiver include:[232]

- Case Management
- IHSS Health Maintenance

CHCBS Statistics	
Total Adjusted Expenditures CY 2019	$43,458,817
Total Members Utilizing Services in CY 2019	1,854
CY 2019 Over CY 2018 Change in Members Utilizing Services	3.00%
Total Active Providers CY 2019	62
CY 2019 Over CY 2018 Change in Active Providers	16.98%

Table 54. CHCBS expenditure and utilization data.

The CHCBS waiver was previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payment for CHCBS services are estimated at 87.71% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[233]

CHCBS Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$43,458,817	$49,548,659	**87.71%**

Table 55. Comparison of Colorado Medicaid CHCBS service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $6,089,842 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. Both procedure codes in this service grouping were compared to an average of eight other states' Medicaid rates.[234] The CHCBS individual

[231] Data used in the rate comparison analysis is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in the CHCBS waiver, see the Health First Colorado Fee Schedule.
[232] A list of procedure codes included in each service grouping is contained in Appendix F.
[233] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[234] States used in the CHCBS rate comparison analysis were Connecticut, Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin. For more details on CHCBS rate comparisons, see Appendix C.

rate ratios ranged from 34.37%-122.61%.[235] A summary of Colorado's expenditures described as a percentage relative to the expenditures of the other seven states is presented below.

CHCBS Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates								
State	CT	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	36.2%	89.5%	75.2%	34.4%	87.9%	122.6%	79.0%	143.6%

Table 56. Comparison of Colorado Medicaid CHCBS service payments to those of eight other states, expressed as a percentage (CY 2019).

Additionally, the Department conducted benchmark comparisons for each service grouping within each waiver. A summary of Colorado's CHCBS service grouping expenditures described as a percentage relative to the average expenditures of eight other states' Medicaid rates is presented below.

CHCBS Service Grouping Rate Benchmark Comparison			
Service Grouping	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Case Management	$1,948,899	$5,524,083	**35.28%**
IHSS Health Maintenance Activities	$41,509,918	$44,024,575	**94.29%**

Table 57. Comparison of Colorado Medicaid CHCBS service grouping payments to those of other payers, expressed as a percentage (CY 2019).[236]

[235] Individual rate ratios for service grouping by state are contained in Appendix C.
[236] Procedure codes included in each service grouping are contained in Appendix F.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for CHCBS services decreased by 11.72% from an average of 22.00 utilizers per provider in CY 2018 to 19.43 utilizers per provider in CY 2019.[237] Additionally:

- In urban counties, panel size averaged 38.85 in CY 2018 and decreased to 31.66 in CY 2019.
- In rural counties, panel size averaged 6.29 in CY 2018 and decreased to 6.07 in CY 2019.

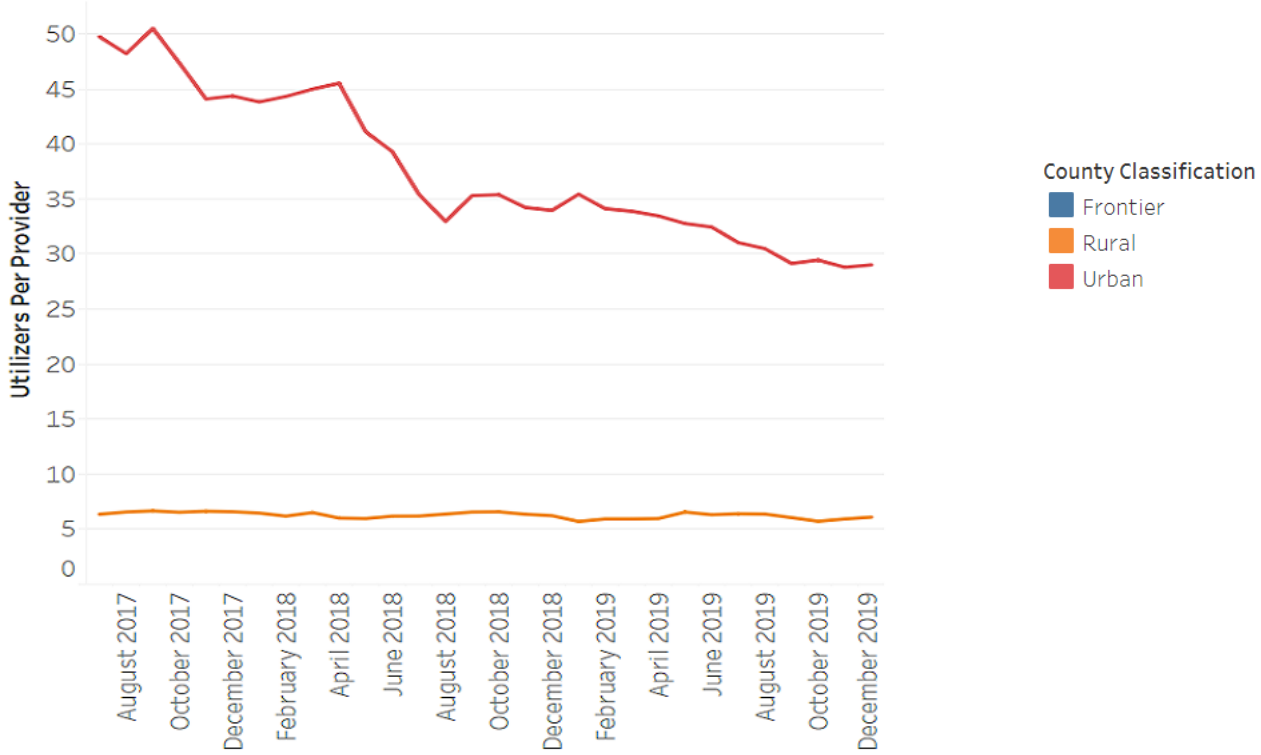

Figure 44. Utilizers per provider (panel size) for CHCBS services between July 2017 to December 2019. [238]

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across all county classifications.

The rate of distinct utilizers and active providers increased at different rates over time, which initially led to a significant decrease in the average panel size in urban counties over time.[239] Since providers are increasing at a higher rate than utilizers over time in urban counties, analyses suggest that the increase in members utilizing services is not negatively impacting access or provider capacity.

[237] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[238] Data from the frontier classification group was blinded for protected health information (PHI), accounting for the missing line in the graph.
[239] For data specific to distinct utilizer and active providers, see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of CHCBS services reside throughout the state. El Paso County had the highest number of utilizers at 567 in CY 2019.

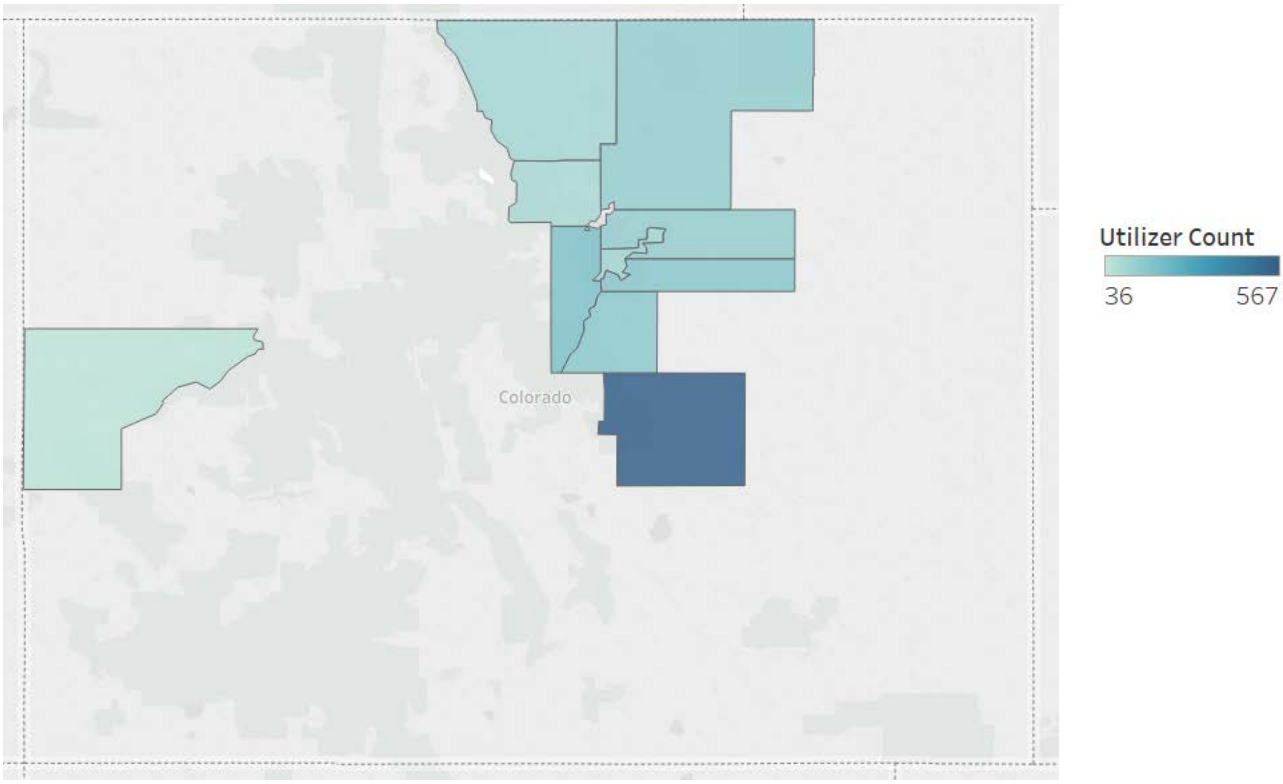

Figure 45. Utilizer density for CHCBS services by county for CY 2019.[240]

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

- relatively lower demand for CHCBS services, or a low number of Colorado Medicaid members utilizing CHCBS services; and
- the CHCBS waiver benefit scope is relatively narrow.

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.

[240] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service. Douglas County had the highest penetration rate at 5.67 in CY 2019.

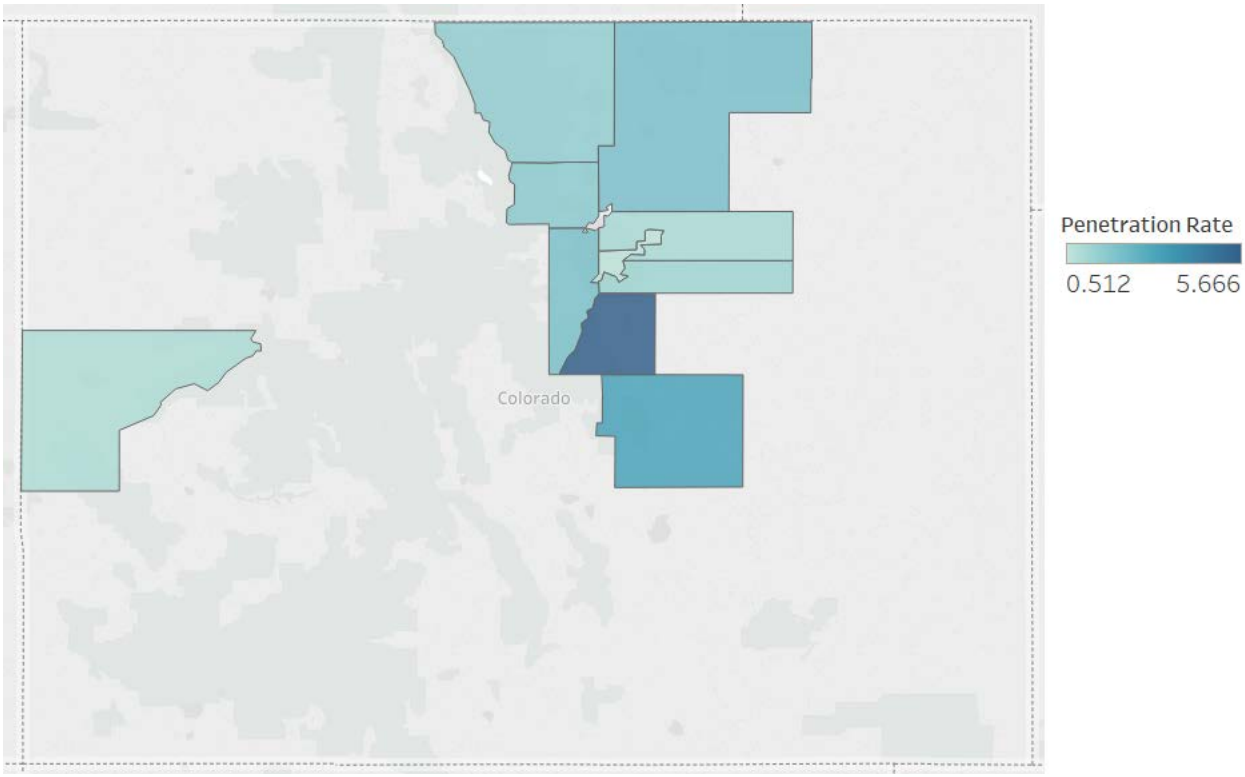

Figure 46. Penetration rates for CHCBS services by county in CY 2019.

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

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.

Member-to-Provider Ratios

The member-to-provider ratio for the CHCBS waiver is calculated as the total number of active CHCBS service providers per 1,000 members ages 0-18.[241]

CHCBS Member-to-Provider Ratios			
Region	**CY 2019 CHCBS Service Providers**	**CY 2019 Total Colorado Medicaid Members Ages 0-18**	**Providers per 1,000 Members**
Frontier	13	17,025	0.76
Rural	29	67,595	0.43
Urban	50	541,874	0.09
Statewide	**62**	**626,753**	**0.10**

Table 58. Member-to-provider ratio for CHCBS services expressed as providers per 1,000 members by county classification in CY 2019.

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.[242]

[241] CHCBS waiver services are only available to recipients from birth through age 17; ages 0-18 is used in this analysis due to data limitations, which had a negligible effect on data results.

[242] Currently, the Department does not use member-to-provider ratio standards specific to CHCBS 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 total Colorado Medicaid members that live within certain drive time bands from where CHCBS services are provided.[243]

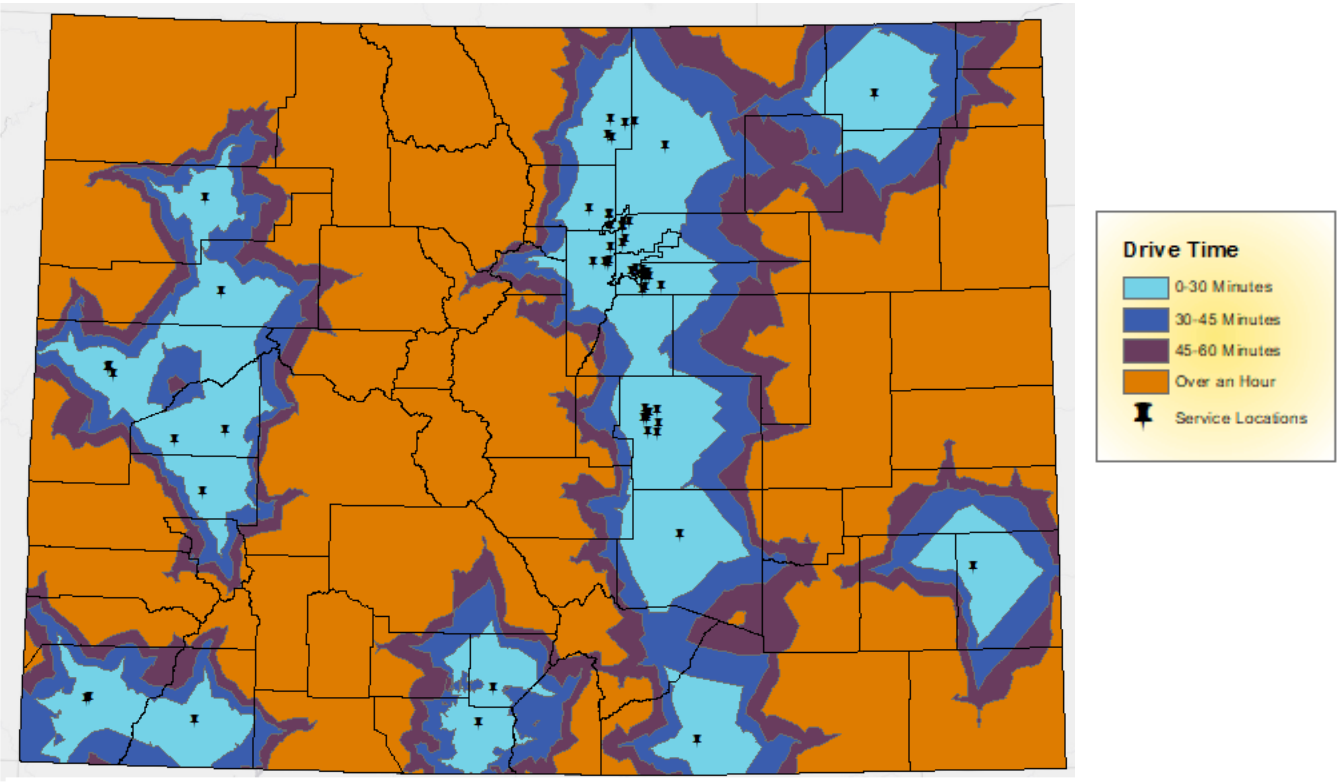

Figure 47. ArcGIS map of drive times of CHCBS service locations to total members in CY 2019.

Overall, 90.40% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a CHCBS provider. Additionally, 3.36% of total members resided approximately 30-45 minutes from a CHCBS provider; 2.48% of total members resided 45-60 minutes from a CHCBS provider. Finally, 3.78% of total members resided over an hour from a CHCBS provider.

[243] Due to claims data, service locations shown on the ArcGIS map represent provider billing locations. CHCBS services are provided in the member home, as well as clinical settings, and caregivers are not necessarily located where the provider billing location is shown on the map. Service locations represent providers that have submitted claims, not all auxiliary CHCBS agencies or individual caregivers.

Stakeholder Feedback

The Department did not receive any feedback specific to the CHCBS waiver or services.

Additional Considerations

Other considerations included:

- In 2018, a new rule version instituted the new case management referral process, which clarified roles and responsibilities for all parties. In addition, the rules outlined documentation and monitoring requirements for agencies and case managers; case managers also began using the IHSS Care Plan Calculator, a tool to help identify service needs for members;
- In February 2021, the Department initiated the case management redesign for HCBS waivers, which refers to several initiatives that will help increase access to case management, as well as improving access to all long-term services and supports;[244] and
- There has been a significant increase in expenditures for CHCBS waiver services, driven by much higher utilization of IHSS health maintenance services; the Department is aware of this change and is continuing to monitor IHSS health maintenance utilization and pursuing further information on the causes driving this significant increase.

Additional Research

The Department will continue to investigate the significant increase in IHSS health maintenance utilization and expenditures.

Conclusion

Analyses suggest CHCBS rates at 87.71% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- Significant increases in distinct utilizers and active providers over time; and
- The significant decrease in panel size, resulting from providers increasing at a greater rate than utilizers of CHCBS services, indicates the increase in utilizers is not impacting others from accessing CHCBS services.

[244] For more information, see the Case Management Redesign web page.

Home and Community-based Services (HCBS) Waivers in Aggregate

Service Description

The aggregate of Waiver Services, for the purposes of this report, is comprised of 41 procedure codes.[245] Waiver services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Aggregate Waiver Services Statistics - Overview	
Total Adjusted Expenditures CY 2019	$1,026,663,091
Total Members Utilizing Services in CY 2019	83,724
CY 2019 Over CY 2018 Change in Members Utilizing Services	2.98%
Total Active Providers CY 2019	4,295
CY 2019 Over CY 2018 Change in Active Providers	3.22%

Table 59. Aggregate Waiver Services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for Aggregate Waiver services are estimated at 97.72% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[246]

Aggregate Waiver Services Rate Benchmark Comparison - Overview		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$1,026,663,091	$1,050,600,975	**97.72%**

Table 59. Comparison of Colorado Medicaid waiver service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $23,937,884 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All 41 of the procedure codes analyzed in this service grouping were compared to an average of eight other states' Medicaid rates.[247] The Waiver services individual rate ratios ranged from 35.28%-316.65%.[248] The following sections present rate comparison analyses using aggregated data across all waivers for each of the following service groupings:

- Adult Day
- Alternative Care Facility (ACF)
- Care Coordination
- Case Management
- Community Connector
- Community Transitions
- Day Habilitation
- Foster Home
- Group Home
- Home Delivered Meals
- Homemaker
- In-Home Support Services (IHSS) – Homemaker, Personal Care, and Health Maintenance Activities
- Life Skills Training (LST) & Independent LST (ILST)
- Non-Medical Transportation (NMT)
- Pain & Symptom Management
- Personal Care
- Prevocational Services
- Professional Therapy Services
- Residential Habilitation
- Respite
- Supported Employment
- Therapy – Behavioral
- Transitional Living Program (TLP)

[245] For a full list of all HCBS waiver services procedure codes, see the Health First Colorado Fee Schedule.
[246] Detailed information regarding the rate comparison analysis methodology is contained in Appendix B.
[247] States used in the waiver services rate comparison analysis were Connecticut, Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin.
[248] Details regarding which procedure codes are included under each service grouping is contained in Appendix F.

Adult Day Services

Adult day services are provided in a community-based setting and encompass both health and social services needed to ensure optimal functioning of the member.[249] The adult day service grouping is comprised of two procedure codes.[250] Analyses in this section refer to adult day services available to members enrolled in the following waivers:

- EBD
- CMHS
- SCI
- BI

For the purposes of this report, adult day services include basic, specialized, and BI adult day.[251]

Aggregate Waiver Statistics – Adult Day Services	
Total Adjusted Expenditures CY 2019	$24,212,821
Total Members Utilizing Services in CY 2019	2,941
CY 2019 Over CY 2018 Change in Members Utilizing Services	0.47%
Total Active Providers CY 2019	78
CY 2019 Over CY 2018 Change in Active Providers	(2.50%)

Table 60. Adult day services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for adult day services are estimated at 84.82% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[252]

Aggregate Waiver Services Rate Benchmark Comparison – Adult Day Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$24,212,821	$28,547,724	**84.82%**

Table 61. Comparison of Colorado Medicaid adult day service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $4,334,903 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. Both of the procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[253] The adult day services individual rate ratios ranged from 70.7%-131.8%.[254] A summary of Colorado's adult day

[249] Basic adult day services include basic social and health services; specialized adult day services provide intensive health supportive services for members with a specific diagnosis requiring extensive rehabilitative therapies.
[250] Data is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in all waivers, see the Health First Colorado Fee Schedule.
[251] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[252] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[253] States used in the adult day services rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[254] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

services expenditures described as a percentage relative to the expenditures of the other six states is presented below.

Adult Day Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	74.9%	70.7%	78.4%	131.8%	93.0%	81.8%

Table 62. Comparison of Colorado Medicaid adult day services payments to those of six other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Adult day services are reimbursed differently under the BI waiver than under the CMHS, EBD, and SCI waivers.[255]

Summary

Colorado payments were between 80% and 100% of the benchmark in 2 states, above 100% in 1 state, and below 80% of the benchmark in 3 states. Analyses are inconclusive to determine if rates for adult day services at 84.82% of the benchmark were sufficient for member access and provider retention. The Department will further investigate reimbursement rates for adult day services to identify potential areas for improving equity of services across waivers.

[255] For a complete list of procedure codes and reimbursement rates for services under all waivers, see the Health First Colorado Fee Schedule.

Alternative Care Facility (ACF)

Alternative Care Facility (ACF) services provide an alternative residential option for eligible members.[256] Analyses in this section refer to ACF services available to members enrolled in the following waivers:

- EBD
- CMHS

For the purposes of this report, ACF services include the per diem reimbursement rate.[257]

Aggregate Waiver Statistics – ACF Services	
Total Adjusted Expenditures CY 2019	$75,836,406
Total Members Utilizing Services in CY 2019	4275
CY 2019 Over CY 2018 Change in Members Utilizing Services	(3.76%)
Total Active Providers CY 2019	291
CY 2019 Over CY 2018 Change in Active Providers	(0.68)

Table 63. ACF services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for ACF services are estimated at 73.14% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[258]

Aggregate Waiver Services Rate Benchmark Comparison – ACF Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$75,836,406	$103,687,422	**73.14%**

Table 64. Comparison of Colorado Medicaid ACF service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $27,851,016 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code[259] analyzed in this service grouping were compared to an average of five other states' Medicaid rates.[260] The ACF services individual rate ratios ranged from 38.3%-107.8%.[261] A summary of Colorado's ACF services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

[256] ACF services include personal care/homemaker services, protective oversight, and medication administration.
[257] This service rate does not incorporate room and board.
[258] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[259] Data is based on claims data and only includes codes that had utilization recorded from March 2017 to December 2019. For a list of procedure codes excluded from this analysis, see Appendix C. For a complete list of procedure codes and services included in all waivers, see the Health First Colorado Fee Schedule.
[260] States used in the ACF services rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[261] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

ACF Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	86.9%	38.3%	93.4%	107.8%	93.0%

Table 65. Comparison of Colorado Medicaid ACF services payments to those of five other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- ACF reimbursement rates received a 25% targeted rate increase (TRI), effective October 2018 as a result of the 2017 Medicaid Provider Rate Review Recommendation Report;[262] and
- Some states reimburse for ACF services using a tiered rate structure, while some, like Colorado, have a single rate for reimbursement.

Summary

Colorado payments were between 80% and 100% of the benchmark in three states, above 100% in one state, and below 80% of the benchmark in one state. Analyses are insufficient to determine if ACF rates at 74.14% of the benchmark were sufficient for member access and provider retention. The Department will further investigate reimbursement rates for assisted living services (e.g., ACF, nursing facility, etc.) to identify potential areas for improving equity of services across waivers. Stakeholder feedback themes include:

- ACF per diem rates are much lower than rates for other similar assisted living facility-based services reimbursed through Colorado Medicaid HCBS waivers (e.g., nursing facilities) and are reportedly not sufficient for provider retention.

[262] See the July 2018 Provider Bulletin for more information.

Care Coordination

Care coordination is provided through HCBS CLLI palliative and supportive care services, which are focused on providing members with relief from symptoms, pain, and the stress of serious illness to improve the quality of life for the member and their family.[263] Care coordination services provide the development and implementation of a care plan, home visits for regular monitoring of the health and safety, and central coordination of medical and psychological services. Analyses in this section refer to services available to members enrolled in the following waivers:

- CLLI

For the purposes of this report, care coordination services include one service rate per 15-minute unit.[264]

Aggregate Waiver Statistics – Care Coordination Services	
Total Adjusted Expenditures CY 2019	$21,728
Total Members Utilizing Services in CY 2019	PHI
CY 2019 Over CY 2018 Change in Members Utilizing Services	8.70%
Total Active Providers CY 2019	1
CY 2019 Over CY 2018 Change in Active Providers	(66.67%)

Table 60. Palliative and supportive care services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for care coordination services are estimated at 69.90% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[265]

Aggregate Waiver Services Rate Benchmark Comparison – Care Coordination Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$21,728	$31,085	**69.90%**

Table 61. Comparison of Colorado Medicaid care coordination service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $4,334,903 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to one other state's Medicaid rates.[266]

Additional Considerations

Other considerations include:

- The Butterfly Program, a provider of care coordination services under the CLLI waiver, closed in late 2018, which led to a slight decrease in utilization; however, increases in active CLLI

[263] Palliative and supportive care services also include pain and symptom management; the rate comparison for pain and symptom management services in included in its own section (page 152).
[264] Detailed information regarding procedure codes reviewed under each service grouping is contained in Appendix F.
[265] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[266] The state used in the care coordination services rate comparison analysis was North Dakota.

providers during this time indicate members' access to CLLI services was not significantly impacted by this closure; the Department will continue to monitor access to these services and whether decrease in active providers for care coordination services is a result of low need for care coordination services or if an access issue may be present, if it is unique to Medicaid, and whether it is attributed to rates.

Summary

Colorado payments were below 80% of the benchmark in North Dakota. Analyses are inconclusive to determine if care coordination rates at 69.90% of the benchmark were sufficient for member access and provider retention. The Department will continue to monitor utilization and further investigate any potential access issues, if they are unique to Medicaid, and whether or not they are attributable to rates. Themes of stakeholder feedback include:

- Providers of care coordination services tend to be concentrated in the Front Range region of Colorado; providers indicate that this is caused by low rates and too few members needing care coordination services to serve rural and frontier counties. As a result, members residing in rural and frontier counties outside of the Front Range region report difficulties finding care coordination providers.

Case Management

Case management services are provided by a case management agency on behalf of a member, which includes referral of needed Medicaid services and supports to enable the child to remain in community-based settings. Analyses in this section refer to case management services available to members enrolled in the following waivers:

- CHCBS

For the purposes of this report, case management services under CHCBS include one service rate reimbursed per 15-minute unit.

Aggregate Waiver Statistics – Case Management Services	
Total Adjusted Expenditures CY 2019	$1,948,899
Total Members Utilizing Services in CY 2019	1,811
CY 2019 Over CY 2018 Change in Members Utilizing Services	1.23%
Total Active Providers CY 2019	22
CY 2019 Over CY 2018 Change in Active Providers	10.00%

Table 63. Case management services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for case management services are estimated at 35.28% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[267]

Aggregate Waiver Services Rate Benchmark Comparison – Case Management Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$1,948,899	$5,524,083	**35.28%**

Table 64. Comparison of Colorado Medicaid case management service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $27,851,016 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure codes analyzed in this service grouping were compared to an average of two other states' Medicaid rates.[268] A summary of Colorado's case management services expenditures described as a percentage relative to the expenditures of the other two states is presented below.

Case Management Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates		
State	CT	ND
Rate Ratio	36.2%	34.4%

Table 65. Comparison of Colorado Medicaid case management services payments to those of two other states, expressed as a percentage (CY 2019).

[267] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[268] States used in the case management services rate comparison analysis were Connecticut and North Dakota.

Additional Considerations

Other considerations include:

- The care and case management redesign/pilot program began February 2021 and is intended to improve access to and quality of case management services for members needing HCBS waivers.[269]

Summary

Colorado payments were below 80% of the benchmark in two states. The utilization and provider retention data are inconclusive to determine if case management services at 35.28% of the benchmark were sufficient for member access and provider retention. The Department will continue to monitor utilization and further investigate any potential access issues, if they are unique to Medicaid, and whether or not they are attributable to rates.

[269] For more information, see the Case Management Redesign web page.

Community Connector

Community connector services are intended to provide assistance that enables the member to integrate into their residential community and access naturally occurring resources. Analyses in this section refer to community connector services available to members enrolled in the following waivers:

- CES

For the purposes of this report, community connector services only refer to services provided under the CES waiver.[270]

Aggregate Waiver Statistics – Community Connector Services	
Total Adjusted Expenditures CY 2019	$6,467,423
Total Members Utilizing Services in CY 2019	967
CY 2019 Over CY 2018 Change in Members Utilizing Services	25.75%
Total Active Providers CY 2019	105
CY 2019 Over CY 2018 Change in Active Providers	1.94%

Table 63. Community connector services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for community connector services are estimated at 255.53% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[271]

Community Connector Services – Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$6,467,423	$2,530,937	**255.53%**

Table 64. Comparison of Colorado Medicaid community connector service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $27,851,016 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure codes analyzed in this service grouping was compared to one other states' Medicaid rates.[272]

Additional Considerations

Additional considerations include:

- Procedure code H2021 is also used to reimburse for intensive supports services and supported community connections on the CHRP waiver, as well as for supported community connections services reimbursement on the SLS waiver;[273] and
- Only one comparator rate was found for this service grouping.

[270] Detailed information regarding procedure codes analyzed under each service is contained in Appendix F.
[271] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[272] The state used in the community connector services rate comparison analysis was Ohio.
[273] For a complete list of procedure codes and reimbursement rates for services under all waivers, see the Health First Colorado Fee Schedule.

Summary

Colorado payments were above 100% in one state. It is difficult to draw conclusions for these services from limited utilization and rate comparison data at this time. The Department will continue to monitor community connector services to identify areas requiring further research, if any.

Community Transitions

Community transitions services are intended to provide assistance that enables the member to integrate into their community and access naturally occurring resources for 365 days post life transition. Analyses in this section refer to community transitions services available to members enrolled in the following waivers:

- BI
- CMHS
- EBD
- DD
- SCI
- SLS[274]

For the purposes of this report, community transitions services include coordinator services rate reimbursed per 15-minute unit, as well as a supply/accessory/service one-time lump sum payment.[275]

Aggregate Waiver Statistics – Community Transitions Services	
Total Adjusted Expenditures CY 2019	$37,249
Total Members Utilizing Services in CY 2019	PHI
CY 2019 Over CY 2018 Change in Members Utilizing Services	1,150%
Total Active Providers CY 2019	12
CY 2019 Over CY 2018 Change in Active Providers	1,100%

Table 63. Community transitions services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for community transitions services are estimated at 84.87% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[276]

Community Transitions Services – Rate Benchmark Comparison		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$37,249	$43,889	**84.87%**

Table 64. Comparison of Colorado Medicaid community transitions service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $6,640 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure codes analyzed in this

[274] Community transitions services are provided on BI, SCI, and SLS waivers and reimbursed the same as CMHS, EBD, and DD waivers; however, no utilization was recorded for community transitions services provided under BI, SCI, and SLS waivers, accounting for the service missing from the BI waiver and SLS waiver sections of the report.
[275] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page. Detailed information regarding procedure codes analyzed under each service is contained in Appendix F.
[276] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

service grouping were compared to an average of four other states' Medicaid rates.[277] The community transitions services individual rate ratios ranged from 62.5%-307.32%.[278] A summary of Colorado's community transitions services expenditures described as a percentage relative to the expenditures of the other four states is presented below.

Community Transitions Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates				
State	MT	OH	OK	UT
Rate Ratio	65.9%	75.0%	62.5%	307.3%

Table 65. Comparison of Colorado Medicaid community transitions services payments to those of four other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Community transitions services were added as a waiver service in 2019; and
- Procedure code A9900 is a one-time payment up to $1,500.

Summary

Colorado payments were above 100% in one state, and below 80% of the benchmark in three states. Analyses suggest community transitions services payments at 84.87% of the benchmark were sufficient for member access and provider retention.

[277] States used in the community transitions services rate comparison analysis were Montana, Ohio, Oklahoma, and Utah.
[278] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Day Habilitation Services

Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the member's private resident or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs. Analyses in this section refer to day habilitation services available to members enrolled in the following waivers:

- DD
- SLS

For the purposes of this report, day habilitation services include specialized habilitation and supported community connections.[279] Specialized habilitation and supported community connections both include six tiered rates reimbursed per 15-minute unit.

Aggregate Waiver Statistics – Day Habilitation Services	
Total Adjusted Expenditures CY 2019	$104,350,295
Total Members Utilizing Services in CY 2019	9326
CY 2019 Over CY 2018 Change in Members Utilizing Services	3.00%
Total Active Providers CY 2019	361
CY 2019 Over CY 2018 Change in Active Providers	10.40%

Table 69. Day habilitation services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for day habilitation services are estimated at 79.56% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[280]

Aggregate Waiver Services Rate Benchmark Comparison – Day Habilitation Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$104,350,295	$131,515,500	**79.56%**

Table 70. Comparison of Colorado Medicaid day habilitation service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $27,165,205 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of six other states' Medicaid rates.[281] The day habilitation services individual rate ratios ranged from 43.9%-214.4%.[282] A summary of Colorado's day habilitation services expenditures described as a percentage relative to the expenditures of the other six states is presented below.

[279] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[280] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[281] States used in the day habilitation services rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[282] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Day Habilitation Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	44.1%	159.5%	76.6%	200.8%	114.7%	55.4%

Table 71. Comparison of Colorado Medicaid day habilitation services payments to those of six other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Virtual and one-on-one service delivery methods were added as billable services under day habilitation and are expected to increase access to these services.[283]

Summary

Colorado payments were above 100% in three states, and below 80% of the benchmark in three states. Analyses are inconclusive to determine if day habilitation rates at 79.56% of the benchmark were sufficient for member access and provider retention. The Department will continue to monitor one-on-one service delivery methods to assess decision to make one-on-one services available permanently.

[283] Virtual service delivery methods were added in March 2020; one-on-one service delivery went into effect March 1, 2021.

Foster Home

Foster home services are a habilitation service that includes self-advocacy, independent living, and emergency assistance training, in addition to cognitive, communication, counseling, therapeutic, personal care, community connector, and supervision services. Analyses in this section refer to foster home services available to members enrolled in the following waivers:

- CHRP

For the purposes of this report, foster home services include six tiered per diem rates.

Aggregate Waiver Statistics – Foster Home Services	
Total Adjusted Expenditures CY 2019	$1,368,229
Total Members Utilizing Services in CY 2019	32
CY 2019 Over CY 2018 Change in Members Utilizing Services	(15.80%)
Total Active Providers CY 2019	12
CY 2019 Over CY 2018 Change in Active Providers	(20.00%)

Table 72. Foster home services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for foster home services are estimated at 133.57% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[284]

Aggregate Waiver Services Rate Benchmark Comparison – Foster Home Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$1,368,229	$1,024,389	**133.57%**

Table 64. Comparison of Colorado Medicaid foster home service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $343,840 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of two other states' Medicaid rates.[285] A summary of Colorado's foster home services expenditures described as a percentage relative to the expenditures of the other two states is presented below.

Foster Home Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates		
State	MT	WI
Rate Ratio	144.58%	124.1%

Table 73. Comparison of Colorado Medicaid foster home services payments to those of two other states, expressed as a percentage (CY 2019).

[284] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[285] States used in the foster home services rate comparison analysis were Montana and Wisconsin.

Summary

Colorado payments were above 100% in two states. Analyses suggest foster home payments at 133.57% of the benchmark were sufficient for member access and provider retention. The Department did not receive any stakeholder feedback regarding foster home services.

Group Home

Group home services are group habilitation services that includes self-advocacy, independent living, and emergency assistance training, in addition to cognitive, communication, counseling, therapeutic, personal care, community connector, and supervision services. Analyses in this section refer to group home services available to members enrolled in the following waivers:

- CHRP

For the purposes of this report, group home services include six tiered per diem rates.[286]

Aggregate Waiver Statistics – Group Home Services	
Total Adjusted Expenditures CY 2019	$165,920
Total Members Utilizing Services in CY 2019	7
CY 2019 Over CY 2018 Change in Members Utilizing Services	(30.00%)
Total Active Providers CY 2019	4
CY 2019 Over CY 2018 Change in Active Providers	(20.00%)

Table 74. Group home services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for group home services are estimated at 102.33% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[287]

Aggregate Waiver Services Rate Benchmark Comparison – Group Home Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$165,920	$162,134	**102.33%**

Table 75. Comparison of Colorado Medicaid group home service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $3,786 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[288] A summary of Colorado's group home services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

Group Home Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	IL	MT	OK	UT
Rate Ratio	157.2%	67.3%	137.3%	120.2%	83.1%

Table 76. Comparison of Colorado Medicaid group home services payments to those of five other states, expressed as a percentage (CY 2019).

[286] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[287] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[288] States used in the group home services rate comparison analysis were Connecticut, Illinois, Montana, Oklahoma, and Utah.

Additional Considerations

Other considerations include:

- Group home services are utilized based on individual need; placement in a group home is not always the most appropriate setting for Colorado Medicaid members enrolled on the CHRP waiver.

Summary

Colorado payments were between 80% and 100% of the benchmark in one state, above 100% in three states, and below 80% of the benchmark in one state. Analyses suggest that group home rates at 102.33% of the benchmark are sufficient for member access and provider retention. The Department did not receive any stakeholder feedback regarding group home services.

Home Delivered Meals Services

Home delivered meal services are offered to members twice daily for up to 365 days post transition. Analyses in this section refer to home delivered meals services available to members enrolled in the following waivers:[289]

- BI
- DD
- CMHS
- EBD
- SCI
- SLS

For the purposes of this report, home delivered meals services include prepared meals delivered daily at a rate of $11.45 for each meal.[290]

Aggregate Waiver Statistics – Home Delivered Meals Services	
Total Adjusted Expenditures CY 2019	$135,816
Total Members Utilizing Services in CY 2019	105
CY 2019 Over CY 2018 Change in Members Utilizing Services	N/A[291]
Total Active Providers CY 2019	3
CY 2019 Over CY 2018 Change in Active Providers	N/A[292]

Table 77. Home delivered meals services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for home delivered meals services are estimated at 193.13% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[293]

Aggregate Waiver Services Rate Benchmark Comparison – Home Delivered Meals Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$135,816	$70,324	**193.13%**

Table 78. Comparison of Colorado Medicaid home delivered meals service payments to those of other payers, expressed as a percentage (CY 2019).

[289] Home delivered meals services are provided on BI, SCI, and SLS waivers and reimbursed the same as CMHS, EBD, and DD waivers; however, no utilization was recorded for home delivered meals services provided under BI, SCI, and SLS waivers, accounting for the service missing from the BI waiver, SCI waiver, and SLS waiver sections of the report.
[290] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[291] Home delivered meals services were added as a HCBS waiver service January 1, 2019; therefore, no utilization was recorded for home delivered meals services in CY 2018, accounting for the missing year-over-year change in members data.
[292] Since no utilization was recorded for home delivered meals services in CY 2018, there were not any active providers (i.e., providers that submitted claims for home delivered meals in at least one month in the last year) that provided home delivered meals services during CY 2018, thus year-over-year change in active providers data is not available.
[293] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

The estimated fiscal impact to Colorado Medicaid would be a savings of $65,492 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[294] A summary of Colorado's home delivered meals services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

Home Delivered Meals Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	225.7%	203.9%	170.4%	222.5%	161.5%

Table 79. Comparison of Colorado Medicaid home delivered meals services payments to those of five other states, expressed as a percentage (CY 2019).

Summary

Colorado payments were above 100% in five states. Analyses suggest home delivered meal services payments at 193.13% of the benchmark were sufficient for member access and provider retention. The Department did not receive any stakeholder feedback regarding home delivered meal services.

[294] States used in the home delivered meals services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.

Homemaker Services

Homemaker services are provided in the member's home to maintain a healthy and safe home environment for the member.[295] Analyses in this section refer to homemaker services available to members enrolled in the following waivers:[296]

- EBD
- CMHS
- SCI
- SLS
- CES

For the purposes of this report, homemaker services include basic and enhanced homemaker services.[297]

Aggregate Waiver Statistics – Homemaker Services	
Total Adjusted Expenditures CY 2019	$40,787,315
Total Members Utilizing Services in CY 2019	10,579
CY 2019 Over CY 2018 Change in Members Utilizing Services	(1.29%)
Total Active Providers CY 2019	472
CY 2019 Over CY 2018 Change in Active Providers	3.96%

Table 80. Homemaker services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for homemaker services are estimated at 122.14% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[298]

Aggregate Waiver Services Rate Benchmark Comparison – Homemaker Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$40,787,315	$33,394,990	**122.14%**

Table 81. Comparison of Colorado Medicaid homemaker service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $7,392,325 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[299] The homemaker services individual rate ratios ranged from 101.02%-201.65%.[300] A summary of

[295] Homemaker services include activities such as light housecleaning, meal preparation, laundry, among others.
[296] IHSS Homemaker services are also available to members enrolled on the EBD and SCI waivers and are analyzed separately; please see the IHSS Homemaker services section for the analysis of IHSS Homemaker services rates.
[297] Homemaker rates for CMHS and EBD waivers are not distinguished by basic and enhanced. As of January 1, 2021, homemaker services for all waivers have location-based rates to include services provided within Denver County and those provided outside Denver County. For more detailed information regarding homemaker rates across waivers, see the Health First Colorado Fee Schedule.
[298] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[299] States used in the homemaker services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.
[300] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Colorado's homemaker services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

Homemaker Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	117.0%	117.6%	118.3%	162.1%	106.5%

Table 82. Comparison of Colorado Medicaid homemaker services payments to those of five other states, expressed as a percentage (CY 2019).

Additional Considerations

- Homemaker service rates, as well as some services provided under the homemaker service grouping, differ across waivers.[301]

Summary

Colorado payments were above 100% in five states. Analyses suggest rates for homemaker services at 122.14% of the benchmark are sufficient for member access and provider retention. The Department will continue to prioritize provider outreach in rural and frontier counties. Themes of stakeholder feedback include:

- Rates are reportedly too low to ensure adequate access to members living in rural and frontier counties.

[301] For detailed reimbursement rates by individual waiver, see the Health First Colorado Fee Schedule.

In-Home Support Services (IHSS) Health Maintenance Activities

In-home support services (IHSS) are provided through a service delivery model that provides members the ability to direct their care, including the hiring and scheduling of attendants. IHSS health maintenance services include routine and repetitive health-related tasks necessary for health and normal bodily functioning. Analyses in this section refer to IHSS health maintenance services available to members enrolled in the following waivers:

- EBD
- SCI
- CHCBS

For the purposes of this report, IHSS health maintenance activities include location-based rates for services provided in Denver County, and those provided outside Denver County.[302]

Aggregate Waiver Statistics – IHSS Health Maintenance Activities	
Total Adjusted Expenditures CY 2019	$118,415,229
Total Members Utilizing Services in CY 2019	4,644
CY 2019 Over CY 2018 Change in Members Utilizing Services	19.32%
Total Active Providers CY 2019	147
CY 2019 Over CY 2018 Change in Active Providers	17.60%

Table 83. IHSS health maintenance services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for IHSS health maintenance activities are estimated at 86.67% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[303]

Aggregate Waiver Services Rate Benchmark Comparison – IHSS Health Maintenance Activities		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$118,415,229	$136,624,189	**86.67%**

Table 84. Comparison of Colorado Medicaid IHSS health maintenance service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $18,208,960 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[304] The IHSS health maintenance activities individual rate ratios ranged from 75.2%-143.6%.[305] A summary of Colorado's

[302]For more detailed information regarding IHSS health maintenance activities rates by location across waivers, see the Health First Colorado Fee Schedule.
[303] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[304] States used in the IHSS health maintenance activities rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, Utah, and Wisconsin.
[305] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

IHSS health maintenance activities expenditures described as a percentage relative to the expenditures of the other six states is presented below.

IHSS Health Maintenance Activities Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	MT	OH	OK	UT	WI
Rate Ratio	89.1%	75.4%	86.4%	97.6%	79.0%	143.6%

Table 84. Comparison of Colorado Medicaid IHSS health maintenance activities payments to those of six other states, expressed as a percentage (CY 2019).

Summary

Colorado payments were between 80% and 100% of the benchmark in three states, above 100% in one state, and below 80% of the benchmark in two states. Analyses suggest IHSS health maintenance activities rates at 86.67% of the benchmark are sufficient for member access and provider retention. The Department will continue to monitor increases in IHSS health maintenance activities utilization and expenditures.

IHSS Homemaker Services

In-home support services (IHSS) are provided through a service delivery model that provides members the ability to direct their care, including the hiring and scheduling of attendants. IHSS homemaker services are provided to an eligible member in their home to maintain a health and safe environment for the member. Analyses in this section refer to IHSS homemaker services available to members enrolled in the following waivers:

- EBD
- SCI

For the purposes of this report, IHSS homemaker services include location-based rates for services provided in Denver County, and those provided outside Denver County.[306]

Aggregate Waiver Statistics – IHSS Homemaker Services	
Total Adjusted Expenditures CY 2019	$14,626,116
Total Members Utilizing Services in CY 2019	1,914
CY 2019 Over CY 2018 Change in Members Utilizing Services	23.48%
Total Active Providers CY 2019	143
CY 2019 Over CY 2018 Change in Active Providers	5.15%

Table 85. IHSS homemaker services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for IHSS homemaker services are estimated at 115.79% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[307]

Aggregate Waiver Services Rate Benchmark Comparison – IHSS Homemaker Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$14,626,116	$12,631,996	**115.79%**

Table 86. Comparison of Colorado Medicaid IHSS homemaker service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $1,994,120 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[308] A summary of Colorado's IHSS homemaker services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

[306] For more detailed information regarding IHSS homemaker rates by location across waivers, see the Health First Colorado Fee Schedule.
[307] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[308] States used in the IHSS homemaker services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.

IHSS Homemaker Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	112.2%	111.8%	111.9%	154.1%	101.0%

Table 87. Comparison of Colorado Medicaid IHSS homemaker services payments to those of five other states, expressed as a percentage (CY 2019).

Summary

Colorado payments were above 100% in five states. Analyses suggest IHSS homemaker rates at 115.79% of the benchmark were sufficient for member access and provider retention.

IHSS Personal Care Services

In-home support services (IHSS) are provided through a service delivery model that provides members the ability to direct their care, including the hiring and scheduling of attendants. IHSS personal care services are intended to meet the member's physical, maintenance, and supportive needs through hand-on assistance or cueing to prompt the member to perform unskilled tasks (e.g., bathing, ambulation, exercises). Analyses in this section refer to IHSS personal care services available to members enrolled in the following waivers:

- EBD
- SCI

For the purposes of this report, IHSS personal care services include location-based rates for services provided in Denver County, and those provided outside Denver County.[309]

Aggregate Waiver Statistics – IHSS Personal Care Services	
Total Adjusted Expenditures CY 2019	$52,140,547
Total Members Utilizing Services in CY 2019	3,798
CY 2019 Over CY 2018 Change in Members Utilizing Services	22.83%
Total Active Providers CY 2019	167
CY 2019 Over CY 2018 Change in Active Providers	7.74%

Table 88. IHSS personal care services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for IHSS personal care services are estimated at 105.64% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[310]

Aggregate Waiver Services Rate Benchmark Comparison – IHSS Personal Care Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$52,140,547	$49,357,740	**105.64%**

Table 89. Comparison of Colorado Medicaid IHSS personal care service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $2,782,807 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[311] A summary of Colorado's IHSS personal care services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

[309] For more detailed information regarding IHSS personal care rates by location across waivers, see the Health First Colorado Fee Schedule.
[310] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[311] States used in the IHSS personal care services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.

IHSS Personal Care Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	84.9%	99.5%	110.3%	122.9%	120.5%

Table 90. Comparison of Colorado Medicaid IHSS personal care services payments to those of five other states, expressed as a percentage (CY 2019).

Summary

Colorado payments were between 80% and 100% of the benchmark in two states and above 100% in three states. Analyses suggest IHSS personal care services payments at 105.64% of the benchmark were sufficient for member access and provider retention.

Life Skills Training & Independent Living Skills Training (ILST)

Life skills training services are individualized training, provided in the member's residence, the community, or group living situation, that is designed and directed with the member to develop and maintain ability to independently sustain themselves in the community. These services are designed to ensure the health, safety, and welfare of the member, and to assist in the acquisition, retention and/or improvement of skills necessary to support the member to live and participate successfully in the community. Analyses in this section refer to life skills training services available to members enrolled in the following waivers:[312]

- EBD
- CMHS
- SCI
- SLS

Life skills training services are restricted to members that are transitioning from an institutional setting to a home and community-based setting; transitioning from a more restrictive community setting to a less restrictive community setting; or experiencing a change in life circumstance. These services are available for 365 days post transition.

Independent Living Skills Training (ILST) are intended to assist with the development and maintenance of the member's ability to sustain him or herself physically, emotionally, and economically in the community (e.g., communication skill building, medication supervisions, benefits and resources coordination).[313] Analyses in this section refer to ILST services available to members enrolled in the following waiver: [314]

- BI

For the purposes of this report, life skills training/ILST services were compared to similar services identified under two other states' Medicaid programs.[315]

Aggregate Waiver Statistics – Life Skills Training Services	
Total Adjusted Expenditures CY 2019	$2,342,091
Total Members Utilizing Services in CY 2019	141
CY 2019 Over CY 2018 Change in Members Utilizing Services	17.50%
Total Active Providers CY 2019	14
CY 2019 Over CY 2018 Change in Active Providers	10.00%

Table 91. Life skills training/ILST services expenditure and utilization data.

[312] Life skills training services were added as billable services under HCBS waivers effective January 1, 2019; these services are provided on SCI and SLS waivers and reimbursed the same as CMHS and EBD waivers; however, no utilization was recorded for life skills trainings services provided under SCI and SLS waivers, accounting for the service missing from the SCI waiver and SLS waiver sections of the report.
[313] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[314] Detailed information regarding the procedure codes reviewed under each service grouping is contained in Appendix F.
[315] States used in the life skills training/ILST services analysis were Connecticut and Montana. Detailed information regarding rate comparison methodology is contained in Appendix C.

Rate Comparison Analysis

On average, Colorado Medicaid payment for life skills training/ILST services are estimated at 130.18% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[316]

Aggregate Waiver Services Rate Benchmark Comparison – Life Skills Training/ILST Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$2,342,091	$1,799,093	**130.18%**

Table 92. Comparison of Colorado Medicaid life skills training/ILST service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $542,998 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The two procedure codes analyzed in this service grouping were compared to an average of two other states' Medicaid rates.[317] A summary of Colorado's life skills training/ILST services expenditures described as a percentage relative to the expenditures of the other two states is presented below.

Life Skills Training/ILST Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates		
State	CT	MT
Rate Ratio	199.6%	96.6%

Table 93. Comparison of Colorado Medicaid life skills training/ILST services payments to those of two other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Life skills training/ILST service benefits vary across waivers;[318] for more detailed information regarding services provided under life skill training/ILST service grouping across waivers, see the Long-Term Services and Supports Benefits and Services Glossary.

Summary

Colorado payments were between 80% and 100% of the benchmark in one state and above 100% in one state. Analyses suggest that Life Skills Training/ILST service payments at 130.18% of the benchmark were sufficient for member access and provider retention.

[316] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[317] States used in the life skills training/ILST services rate comparison analysis were Connecticut and Montana.
[318] In February 2020, ILST rates under the BI waiver were aligned with life skills training services rates on the CMHS, EBD, SCI, and SLS waivers, when the service unit was changed from 1-hour to 15-minutes.

Non-Medical Transportation (NMT)

Non-medical transportation (NMT) services are provided for members to access non-medical community services and resources and can include trips required by the care plan to prevent institutionalization (e.g., to and from adult day services). Analyses in this section refer to NMT services available to members enrolled in the following waivers:

- EBD
- DD
- CMHS
- SLS
- SCI
- BI

For the purposes of this report, NMT services include minibus and wheelchair van one-way trips on all waivers listed above, as well as per trip for NMT services on DD and SLS waivers, reimbursed at various mileage bands based on distance.[319]

Aggregate Waiver Statistics – NMT Services	
Total Adjusted Expenditures CY 2019	$30,538,337
Total Members Utilizing Services in CY 2019	11,478
CY 2019 Over CY 2018 Change in Members Utilizing Services	1.58%
Total Active Providers CY 2019	418
CY 2019 Over CY 2018 Change in Active Providers	5.56%

Table 94. NMT services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for NMT services are estimated at 86.98% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[320]

Aggregate Waiver Services Rate Benchmark Comparison – NMT Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$30,538,337	$35,111,106	**86.98%**

Table 95. Comparison of Colorado Medicaid NMT service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $4,572,769 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All four of the procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[321] The NMT services individual rate ratios ranged from 56.21%-265.8%.[322] A summary of Colorado's NMT

[319] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[320] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[321] States used in the NMT services rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[322] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

expenditures described as a percentage relative to the expenditures of the other six states is presented below.

NMT Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	67.7%	91.2%	87.1%	62.5%	133.1%	127.9%

Table 96. Comparison of Colorado Medicaid NMT services payments to those of six other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- NMT services received a 6.61% targeted rate increase (TRI), effective July 2018, as a result of the 2017 Medicaid Provider Rate Review Recommendation Report;[323] and
- NMT services are reimbursed at varying rates across waivers; for detailed information on reimbursement rates for NMT services across waivers, see the Colorado Medicaid Fee Schedule.

Summary

Colorado payments were between 80% and 100% of the benchmark in two states, above 100% in two states, and below 80% of the benchmark in two states. Analyses suggest NMT service payments at 86.98% of the benchmark were sufficient for member access and provider retention. The Department will investigate rate disparities for NMT services across waivers to identify areas, if any, for improving rate equity across waivers.

[323] NMT services on the EBD, CMHS, SCI, BI, SLS, and DD waivers received the 6.61% TRI.

Pain & Symptom Management

Pain and symptom management are provided under HCBS CLLI palliative and supportive care services, which are focused on providing members with relief from symptoms, pain, and the stress of serious illness to improve the quality of life for the member and their family.[324] Pain and symptom management services provide for in-home management of a member's symptoms and pain by a registered nurse (RN). Analyses in this section refer to services available to members enrolled in the following waivers:

- CLLI

For the purposes of this report, pain and symptom management services include one service rate for in-home nursing care provided by an RN, reimbursed per 1-hour unit.

Aggregate Waiver Statistics – Pain & Symptom Management Services	
Total Adjusted Expenditures CY 2019	$33,488
Total Members Utilizing Services in CY 2019	PHI
CY 2019 Over CY 2018 Change in Members Utilizing Services	13.64%
Total Active Providers CY 2019	1
CY 2019 Over CY 2018 Change in Active Providers	(66.67%)

Table 60. Pain and symptom management services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for pain and symptom management services are estimated at 141.63% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[325]

Aggregate Waiver Services Rate Benchmark Comparison – Pain & Symptom Management Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$33,488	$23,645	**141.63%**

Table 61. Comparison of Colorado Medicaid pain and symptom management service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $9,843 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to one other state's Medicaid rates.[326]

Additional Considerations

Other considerations include:

- The Colorado rate for pain and symptom management services has a Medicaid Doctor (MD) visit built into the rate, which may account for the high rate benchmark comparison to North Dakota; and

[324] Palliative and Supportive Care services also includes care coordination; the rate comparison for care coordination services in included in its own section (page 124).
[325] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[326] The state used in the pain and symptom management services rate comparison analysis was North Dakota.

- The Butterfly Program, a provider of pain and symptom management services under the CLLI waiver, closed in late 2018, which led to a slight decrease in utilization; however, increases in members utilizing these services and number of overall CLLI providers during this time indicate members' access to CLLI services was not significantly impacted by this closure; the Department will continue to monitor access to these services and whether decrease in active providers for pain and symptom management services is a result of low need for these services or if an access issue may be present, if it is unique to Medicaid, and whether or not it is attributable to rates.

Summary

Colorado payments were above 100% in North Dakota. Analyses suggest pain and symptom management services payments at 141.63% of the benchmark were sufficient for member access and provider retention. Themes of stakeholder feedback included:

- Providers of pain and symptom management services tend to be concentrated in the Front Range region of Colorado; providers indicate that this is caused by low rates and too few members needing care coordination services to serve rural and frontier counties. As a result, members residing in rural and frontier counties outside of the Front Range region report difficulties finding pain and symptom management providers.

Personal Care Services

Personal care services are intended to meet the member's physical, maintenance and supportive needs through hands-on assistance or cueing to prompt the member to perform unskilled tasks (e.g., bathing, ambulation, exercises). Analyses in this section refer to personal care services available to members enrolled in the following waivers:

- EBD
- CMHS
- SLS
- SCI
- BI

For the purposes of this report, personal care services include rates for personal care services provided by professional caregiver, as well as relative-provided care.[327]

Aggregate Waiver Statistics – Personal Care Services	
Total Adjusted Expenditures CY 2019	$153,981,204
Total Members Utilizing Services in CY 2019	13,754
CY 2019 Over CY 2018 Change in Members Utilizing Services	(5.10%)
Total Active Providers CY 2019	452
CY 2019 Over CY 2018 Change in Active Providers	4.87%

Table 63. Personal care services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for personal care services are estimated at 106.32% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[328]

Aggregate Waiver Services Rate Benchmark Comparison – Personal Care Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$153,981,204	$144,826,125	**106.32%**

Table 64. Comparison of Colorado Medicaid personal care service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $9,155,079 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[329] The personal care services individual rate ratios ranged from 84.89%-144.14%.[330] A summary of Colorado's personal care services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

[327] Personal care service rates vary across services; personal care services for all waivers have location-based rates to include services provided within Denver County and those provided outside Denver County. For more detailed information regarding personal care services rates across waivers, see the Health First Colorado Fee Schedule.
[328] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[329] States used in the personal care services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.
[330] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Personal Care Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	85.4%	100.1%	111.0%	123.7%	121.2%

Table 65. Comparison of Colorado Medicaid personal care services payments to those of five other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Personal care service rates vary across services; SLS personal care rates reimburse slightly higher than personal care services under BI, CMHS, EBD, and SCI;[331] and
- Personal care services were removed from the CES waiver in 2015 and are now available to Colorado Medicaid members ages 0-20 through pediatric personal care services now offered as a State Plan benefit.[332]

Summary

Colorado payments were between 80% and 100% of the benchmark in one state and above 100% in four states. Analyses suggest that personal care service payments at 106.32% of the benchmark are sufficient for member access and provider retention. The Department will continue to investigate personal care rate disparities across waivers to identify any areas for improving rate equity across waivers. Themes of stakeholder feedback for personal care services include:

- Rates are too low to ensure adequate access to members living in rural and frontier counties.

[331] For detailed information on personal care service rates across services, see the Health First Colorado Fee Schedule.
[332] Pediatric personal care services were reviewed in the 2020 Medicaid Provider Rate Review Analysis Report.

Prevocational Services

Prevocational services are provided to prepare a member for paid employment in the community.[333] Analyses in this section refer to prevocational services available to members enrolled in the following waivers:

- DD
- SLS

For the purposes of this report, prevocational services include one procedure code for six levels of prevocational service based on complexity.[334]

Aggregate Waiver Statistics – Prevocational Services	
Total Adjusted Expenditures CY 2019	$2,579,449
Total Members Utilizing Services in CY 2019	496
CY 2019 Over CY 2018 Change in Members Utilizing Services	(27.80%)
Total Active Providers CY 2019	28
CY 2019 Over CY 2018 Change in Active Providers	(31.71%)

Table 60. Prevocational services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for prevocational services are estimated at 77.81% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[335]

Aggregate Waiver Services Rate Benchmark Comparison – Prevocational Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$2,579,449	$3,314,898	**77.81%**

Table 61. Comparison of Colorado Medicaid prevocational service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $735,449 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[336] The prevocational services individual rate ratios ranged from 37.4%-192.5%.[337] A summary of Colorado's prevocational services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

[333] Prevocational services teach concepts such as attendance, task completion, problem solving, and safety.
[334] For more details regarding prevocational rates by level of services, see the Health First Colorado Fee Schedule.
[335] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[336] States used in the prevocational services rate comparison analysis were Connecticut, Montana, Ohio, Oklahoma, and Utah.
[337] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Prevocational Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	MT	OH	OK	UT
Rate Ratio	48.0%	179.1%	164.5%	111.5%	44.1%

Table 62. Comparison of Colorado Medicaid prevocational services payments to those of five other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Prevocational services are being utilized less since it is no longer considered a best practice; specialized habilitation services have become the preferential method for providing these types of services.[338]

Summary

Colorado payments were above 100% in three states and below 80% of the benchmark in two states. Analyses suggest that prevocational service payments at 77.81% of the benchmark were sufficient for member access and provider retention. The Department did not receive any feedback from stakeholders regarding prevocational services.

[338] This is in alignment with the statewide initiative to emphasize competitive integrated employment as an Employment First state.

Professional Therapy Services

Professional therapy services include several therapeutic and integrative health services. For the purposes of this report, professional therapy services include massage therapy, movement therapy, hippotherapy, expressive therapy, end of life/bereavement counseling, acupuncture and chiropractic services.[339] Short descriptions of each service are listed below.

Massage therapy services include physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation, and decrease muscle tension, and includes Watsu, to provide members with beneficial physiologic, mechanical, and/or psychological changes. Analyses in this section refer to massage therapy services available to members enrolled in the following waivers:[340]

- CLLI[341]
- CES
- CHRP
- SLS
- SCI[342]

Movement therapy services include the use of music or dance as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills, and assists in pain management and cognition. Analyses in this section refer to movement therapy services available to members enrolled in the following waivers:[343]

- CES
- CHRP
- SLS

Hippotherapy services includes therapeutic treatment strategies that uses the movement of the horse to assist in the development or enhancement of sills including gross motor, sensory integration, attention, cognitive, social, behavior and communication. Analyses in this section refer to movement therapy services available to members enrolled in the following waivers:[344]

- SLS
- CES
- CHRP

Expressive therapy includes creative art, music, or play therapy and provides members the ability to creatively and kinesthetically express their medical situation, express feelings of isolation, improve

[339] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[340] Massage therapy services are provided under all five waivers listed in this section. Massage therapy service rates vary across waivers; for more details on massage therapy rates across waiver, see the Health First Colorado Fee Schedule.
[341] Professional therapy services on the CLLI waiver include massage therapy, end of life counseling, and expressive therapy; these services differ under SLS, CES, and CHRP waiver. Detailed information on procedure codes reviewed under each waiver and service is contained in Appendix F.
[342] Professional therapy services on the SCI waiver are known as complimentary & integrative health services and include massage therapy, acupuncture, and chiropractic services; acupuncture and chiropractic services are unique to the SCI waiver.
[343] Movement therapy service rates vary across waivers and are based on provider level of education; for more details regarding movement therapy service rates by level of education across waivers, see the Health First Colorado Fee Schedule.
[344] For more details regarding hippotherapy service rates by level of education, see the Health First Colorado Fee Schedule.

communication skills, manage emotional suffering, and develop coping skills.[345] Analyses in this section refer to expressive therapy services available to members enrolled in the following waiver:

- CLLI

Therapeutic life-limiting illness support services include grief or anticipatory grief counseling that help members and families cope with emotional suffering, feelings of isolation, and the member's life-limiting diagnosis. End of life/ bereavement counseling services are provided to members and/or family members to help cope with the member's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Analyses in this section refer to therapeutic life-limiting illness support services and end of life/bereavement counseling services available to members enrolled in the following waiver:[346]

- CLLI

Acupuncture services provide members with beneficial physiologic and/or psychological changes. Chiropractic services provide members with the goal of correcting alignment of the spine or other parts of the body and correcting other musculoskeletal problems. Analyses in this section refer to acupuncture and chiropractic services available to members enrolled in the following waiver:

- SCI

Aggregate Waiver Statistics – Professional Therapy Services	
Total Adjusted Expenditures CY 2019	$6,753,308
Total Members Utilizing Services in CY 2019	1,964
CY 2019 Over CY 2018 Change in Members Utilizing Services	9.17%
Total Active Providers CY 2019	65
CY 2019 Over CY 2018 Change in Active Providers	(4.41%)

Table 63. Professional therapy services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for professional therapy services are estimated at 106.34% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[347]

Aggregate Waiver Services Rate Benchmark Comparison – Professional Therapy Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$6,753,308	$6,350,556	**106.34%**

Table 64. Comparison of Colorado Medicaid professional therapy service payments to those of other payers, expressed as a percentage (CY 2019).

[345] Expressive therapy service rates include individual and group levels of music, as well as art and play therapy; for more details regarding expressive therapy service rates, see the Health First Colorado Fee Schedule.
[346] Therapeutic life-limiting illness support service rates include individual and group levels of counseling services; end of life/bereavement counseling services are reimbursed as a one-time lump sum per member. For more detailed information regarding service-specific rates, see the Health First Colorado Fee Schedule.
[347] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

The estimated fiscal impact to Colorado Medicaid would be a savings of $402,752 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All seven of the procedure codes analyzed in this service grouping were compared to an average of seven other states' Medicaid rates.[348] The professional therapy services individual rate ratios ranged from 57.1%-306.8%.[349] A summary of Colorado's professional therapy services expenditures described as a percentage relative to the expenditures of the other seven states is presented below.

Professional Therapy Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates							
State	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	207.5%	87.2%	100.5%	291.5%	95.3%	66.4%	129.9%

Table 65. Comparison of Colorado Medicaid professional therapy services payments to those of seven other states, expressed as a percentage (CY 2019).

Additional Considerations

Additional considerations include:

- Professional therapy services offered varies across waivers;[350]
- Massage therapy services are paid at a lower rate on the SCI waiver compared to other waivers;[351]
- Some professional therapy services are paid at various rates by education level (e.g., whether the provider has a bachelor's or master's degree).

Summary

Colorado payments were between 80% and 100% of the benchmark in two states, above 100% in four states, and below 80% of the benchmark in one state. Analyses are inconclusive to determine if professional therapy services payments at 106.34% of the benchmark were sufficient for member access and provider retention. Themes of stakeholder feedback include:

- Massage therapy rates are reportedly too low for adequate access in rural and frontier counties;
- Massage therapy rates are reportedly too low under the SCI waiver for member access and provider retention; and
- There is a reportedly low number of providers of hippotherapy services.

[348] States used in the professional therapy services rate comparison analysis were Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin.
[349] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.
[350] Details regarding services and procedure codes reviewed under each waiver and service grouping are contained in Appendix F.
[351] For detailed HCBS rates information, see the Health First Colorado Fee Schedule.

Residential Habilitation Services

Residential habilitation services provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training (e.g., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each person determined by the assessed needs, personal goals, and other input provided by the Interdisciplinary Team, defined at 10 CCR 2505-10, Section 8.519.1, and to provide access to and participation in typical activities and functions of community life. Analyses in this section refer to residential habilitation services available to members enrolled in the following waivers:

- DD

For the purposes of this report, residential habilitation services include group residential services and supports, individual residential services and supports, and individual residential services and supports/host homes.[352]

Aggregate Waiver Statistics – Residential Habilitation Services	
Total Adjusted Expenditures CY 2019	$332,486,308
Total Members Utilizing Services in CY 2019	6,457
CY 2019 Over CY 2018 Change in Members Utilizing Services	9.00%
Total Active Providers CY 2019	305
CY 2019 Over CY 2018 Change in Active Providers	5.54%

Table 60. Residential habilitation services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for residential habilitation services are estimated at 110.68% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[353]

Aggregate Waiver Services Rate Benchmark Comparison – Residential Habilitation Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$332,486,308	$300,410,489	**110.68%**

Table 61. Comparison of Colorado Medicaid residential habilitation service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $32,075,819 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. The one procedure code analyzed in this service grouping was compared to an average of five other states' Medicaid rates.[354] The residential habilitation services individual rate ratios ranged from 74.1%-146.3%.[355] A summary of

[352] Residential habilitation rates are reimbursed through tiered rates based on complexity. For more detailed information regarding residential habilitation service rates, see the Health First Colorado Fee Schedule.
[353] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[354] States used in the residential habilitation services rate comparison analysis were Connecticut, Illinois, Montana, Oklahoma, and Utah.
[355] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Colorado's residential habilitation services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

Residential Habilitation Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	IL	MT	OK	UT
Rate Ratio	139.6%	146.3%	120.3%	106.7%	74.1%

Table 62. Comparison of Colorado Medicaid residential habilitation services payments to those of six other states, expressed as a percentage (CY 2019).

Summary

Colorado payments were above 100% in four states and below 80% of the benchmark in one state. Analyses suggest residential habilitation rates at 110.68% of the benchmark were sufficient for member access and provider retention.

Respite Services

Respite services are provided to members on a short-term basis because of the absence or need for relief of those persons normally providing care. Analyses in this section refer to respite services available to members enrolled in the following waivers:

- EBD
- CMHS
- SCI
- SLS
- CES
- CLLI
- BI
- CHRP

For the purposes of this report, respite services include unskilled in-home respite; in-home respite provided by Certified Nursing Aid (CNA), Registered Nurse (RN), or Licensed Practical Nurse (LPN); and both ACF and nursing facility respite.[356]

Aggregate Waiver Statistics – Respite Services	
Total Adjusted Expenditures CY 2019	$18,116,020
Total Members Utilizing Services in CY 2019	3,018
CY 2019 Over CY 2018 Change in Members Utilizing Services	4.10%
Total Active Providers CY 2019	366
CY 2019 Over CY 2018 Change in Active Providers	1.10%

Table 63. Respite services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for respite services are estimated at 115.56% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[357]

Aggregate Waiver Services Rate Benchmark Comparison – Respite Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$18,116,020	$15,676,493	**115.56%**

Table 64. Comparison of Colorado Medicaid respite service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $2,439,527 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All five of the procedure codes analyzed in this service grouping were compared to an average of eight other states' Medicaid

[356] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[357] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

rates.[358] The respite services individual rate ratios ranged from 45.6%-307.8%.[359] A summary of Colorado's respite services expenditures described as a percentage relative to the expenditures of the other eight states is presented below.

Respite Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates								
State	CT	IL	MT	ND	OH	OK	UT	WI
Rate Ratio	133.5%	68.1%	106.1%	120.0%	157.4%	158.9%	110.6%	125.4%

Table 65. Comparison of Colorado Medicaid respite services payments to those of eight other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- Respite services rates, as well as services provided under the respite service grouping, vary across waivers.[360]

Summary

Colorado payments were above 100% in seven states and below 80% of the benchmark in one state. Analyses suggest respite payments at 115.56% of the benchmark were sufficient for member access and provider retention. The Department will continue to investigate rate disparities for respite services across waiver to identify areas, if any, for improving rate equity across waivers. Themes of stakeholder feedback include:

- Reportedly low rates for skilled respite services; and
- Both skilled and unskilled respite services rates under the CLLI waiver are higher than rates for the same services on other waivers; stakeholder indicate that these services should be reimbursed at the same rates as under the CLLI waiver.

[358] States used in the respite services rate comparison analysis were Connecticut, Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah, and Wisconsin.
[359] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.
[360] For more information on respite services rates across waivers, see the Health First Colorado Fee Schedule.

Supported Employment Services

Supported employment services are focused on activities needed to sustain paid work by members (e.g., supervision and training) or focus on assessment and identification of vocational interests and capabilities in preparation for job development, as well as assisting in the location of a job or job placement.[361] Analyses in this section refer to supported employment services available to members enrolled in the following waivers:

- DD
- SLS

For the purposes of this report, supported employment services include job coaching, job development, and job placement.[362]

Aggregate Waiver Statistics – Supported Employment Services	
Total Adjusted Expenditures CY 2019	$28,935,026
Total Members Utilizing Services in CY 2019	3080
CY 2019 Over CY 2018 Change in Members Utilizing Services	2.33%
Total Active Providers CY 2019	156
CY 2019 Over CY 2018 Change in Active Providers	9.09%

Table 60. Supported employment services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for supported employment services are estimated at 93.28% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[363]

Aggregate Waiver Services Rate Benchmark Comparison – Supported Employment Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$28,935,026	$31,020,533	**93.28%**

Table 61. Comparison of Colorado Medicaid supported employment service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be $2,085,507 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All three of the procedure codes analyzed in this service grouping were compared to an average of six other states' Medicaid rates.[364] The supported employment services individual rate ratios ranged from 42.6%-255.1%.[365] A summary of Colorado's supported employment services expenditures described as a percentage relative to the expenditures of the other six states is presented below.

[361] These services may only be reimbursed by Colorado Medicaid if members are not able to access them through the Department of Vocational Rehabilitation (DVR).
[362] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[363] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[364] States used in the supported employment services rate comparison analysis were Connecticut, Illinois, Montana, Ohio, Oklahoma, and Utah.
[365] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Supported Employment Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates						
State	CT	IL	MT	OH	OK	UT
Rate Ratio	84.5%	242.3%	76.7%	56.6%	219.2%	76.3%

Table 62. Comparison of Colorado Medicaid supported employment services payments to those of six other states, expressed as a percentage (CY 2019).

Additional Considerations

- These services are only available for reimbursement through Colorado Medicaid if members are not able to access them through DVR.

Summary

Colorado payments were between 80% and 100% of the benchmark in one state, above 100% in two states, and below 80% of the benchmark in three states. Analyses indicate that payments for supported employment services at 93.28% of the benchmark were sufficient for member access and provider retention.

Therapy – Behavioral Services

Therapy – behavioral services include both mental health counseling and behavioral services. Mental health counseling services are individualized to assist the member and their support systems to effectively manage and overcome the difficulties and stresses confronted by people with disabilities. Behavioral services are provided to an individual with an intellectual and developmental disability which assist an individual to acquire or maintain appropriate interactions with others.[366] Analyses in this section refer to therapy – behavioral services available to members enrolled in the following waivers:

- DD
- SLS
- BI[367]

For the purposes of this report, therapy – behavioral services include mental health counseling, behavioral line staff, individual and group counseling, consultation, and behavioral plan assessment.[368]

Aggregate Waiver Statistics – Therapy - Behavioral Services	
Total Adjusted Expenditures CY 2019	$10,319,565
Total Members Utilizing Services in CY 2019	2,850
CY 2019 Over CY 2018 Change in Members Utilizing Services	4.17%
Total Active Providers CY 2019	131
CY 2019 Over CY 2018 Change in Active Providers	(7.09%)

Table 63. Therapy – behavioral services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payment for therapy – behavioral services are estimated at 142.04% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[369]

Aggregate Waiver Services Rate Benchmark Comparison – Therapy - Behavioral Services		
Colorado Repriced	**Comparison Repriced**	**Rate Benchmark Comparison**
$10,319,565	$7,265,326	**142.04%**

Table 64. Comparison of Colorado Medicaid therapy – behavioral service payments to those of other payers, expressed as a percentage (CY 2019).

The estimated fiscal impact to Colorado Medicaid would be a savings of $3,054,239 in total funds if Colorado had reimbursed at 100% of the combined benchmark in CY 2019. All three of the procedure codes analyzed in this service grouping were compared to an average of five other states' Medicaid

[366] Therapy – behavioral services vary across waivers. Detailed information regarding procedure codes included under each service grouping by waiver is contained in Appendix F.
[367] BI therapy – behavioral services include mental health and substance abuse counseling for group and individual settings; DD and SLS therapy – behavioral services include behavioral line staff, individual and group counseling, consultation, and behavioral plan assessment. Detailed information regarding procedure codes included under each service grouping by waiver is contained in Appendix F.
[368] The Rate Review Process is intended to review categories of service groupings at a high level. For more information see the Rate Review Process web page.
[369] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.

rates.[370] The therapy – behavioral services individual rate ratios ranged from 64.8%-351.2%.[371] A summary of Colorado's therapy – behavioral services expenditures described as a percentage relative to the expenditures of the other five states is presented below.

Therapy – Behavioral Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates					
State	CT	IL	MT	OK	UT
Rate Ratio	93.4%	345.3%	175.9%	102.2%	163.1%

Table 65. Comparison of Colorado Medicaid therapy – behavioral services payments to those of five other states, expressed as a percentage (CY 2019).

Additional Considerations

Other considerations include:

- In January 2018, behavioral services for children were removed from waivers and are now available to all Colorado Medicaid members ages 0-20 through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Analyses indicate there have been significant increases in utilization and providers of these services since January 2018, indicating stakeholder concerns regarding access to pediatric behavioral services have been addressed by the change.

Summary

Colorado payments were between 80% and 100% of the benchmark in one state and above 100% in four states. Analyses suggest that therapy – behavioral payments at 142.04% of the benchmark were sufficient for member access and provider retention.

[370] States used in the therapy – behavioral services rate comparison analysis were Connecticut, Illinois, Montana, Oklahoma, and Utah.
[371] Individual rate ratios for each waiver and each waiver service grouping are contained in Appendix C.

Transitional Living Program (TLP) Services

Transitional Living Program (TLP), or transitional living services, are post-acute residential services provided in a residential setting and are designed to improve the member's ability to live in the community by provision of 24-hour services, supports, and supervision.[372] TLP services are comprised of one procedure code.[373] Analyses in this section refer to TLP services available to members enrolled in the following waivers:

- BI

For the purposes of this report, TLP services includes five levels of service based on complexity; TLP service rates are reimbursed using five tiered per diem rates based on member acuity scores determined by the Department.

Aggregate Waiver Statistics – TLP Services	
Total Adjusted Expenditures CY 2019[374]	$64,303
Total Members Utilizing Services in CY 2019	PHI
CY 2019 Over CY 2018 Change in Members Utilizing Services	0.00%
Total Active Providers CY 2019	1
CY 2019 Over CY 2018 Change in Active Providers	0.00%

Table 63. TLP services expenditure and utilization data.

Rate Comparison Analysis

The Department was unable to identify appropriate service rates for comparison of TLP services. As a result, rate comparison data is not available for these services.

Additional Considerations

Additional considerations include:

- The Department has received feedback from providers that they would provide these services to Medicaid members more often if the reimbursement rate was increased to cover costs associated with providing TLP services;
- TLP services are very unique and provide highly acute levels of care; Colorado provides a variety of different services under the TLP service grouping that are not provided by other states.[375]

Summary

It is difficult to make conclusions based on limited utilization and provider data. The Department is currently investigating TLP rate setting methodology to identify opportunities, if any, to improve access to care and provider retention.

[372] TLP services and supports include medication management, communication skills, and socialization, among others. These services are only available for members that are transitioning from a hospital-based setting.
[373] Detailed information regarding procedure codes analyzed under each service is contained in Appendix F.
[374] Due to data lack of utilization for levels one, two, and four, only levels three and five of TLP service rates were available for rate comparison analysis in this report.
[375] TLP data, while limited, is included here to maintain a record of historical data throughout the Medicaid Provider Rate Review Process.

Targeted Case Management (TCM)

Service Description

The Targeted Case Management (TCM) service grouping is comprised of three procedure codes. TCM services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

TCM Statistics	
Total Adjusted Expenditures CY 2019	$55,285,876
Total Members Utilizing Services in CY19	42,562
CY 2019 Over CY 2018 Change in Members Utilizing Services	8.99%
Total Rendering Providers CY 2019	2,468
CY 2019 Over CY 2018 Change in Rendering Providers	7.82%

Table 20. TCM expenditure and utilization data.

Due to the recent change in rate reimbursement methodology for TCM services from a procedure-code based fee schedule to a per-member-per-month reimbursement methodology, the Department has conducted a modified analysis using a straight rate-to-rate comparison of the PMPM rate to other states' Medicaid programs that use similar PMPM methodology. The modified review does not adjust for utilization; however, utilization data from previous years was available to conduct the typical access to care analysis, which is included following the modified Rate Comparison Analysis section.

Modified Rate Comparison Analysis

On average, Colorado Medicaid payment for TCM services are estimated at 87.84% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[376]

TCM Rate Benchmark Comparison – PMPM Rate to an average of Other States' PMPM Rate		
Colorado PMPM Rate	**Comparison Average PMPM Rate**	**Rate Benchmark Comparison**
$138.29	$157.43	**87.84%**

Table 21. Comparison of Colorado Medicaid TCM per member per month (PMPM) rate to those of other payers, expressed as a percentage (CY 2019).

All procedure codes analyzed in this service grouping were compared to an average of four other states' Medicaid rates.[377] Results of the modified rate comparison analysis showing Colorado as a percentage of each state's rate is presented below.

[376] Detailed information regarding the rate comparison analysis methodology is contained in Appendix C.
[377] States used in the TCM rate comparison analysis were Connecticut, Indiana, Montana, and Utah.

TCM Services Benchmark Comparison – Colorado as a Percentage of Other States' Medicaid Rates				
State	**Source**	**Service**	**PMPM Rate**	**CO as a Percent of the Benchmark**
CT	1915(c) HCBS for Elders Waiver	Case Management Daily Rate[378]	$152.70	**90.56%**
IN	1915(c) Aged and Disabled Waiver	Care Management	$134.33	**102.95%**
MT	1915(c) 0208 HCBS DD Waiver	Case Management	$134.82	**102.57%**
UT	1915(c) Community Supports Waiver	Waiver Support Coordination	$201.88	**66.52%**

Table 11. Comparison of Colorado Medicaid TCM PMPM rate to those of four other states, expressed as a percentage (CY 2019).[379]

[378] The rate used for the Connecticut comparison is based on a per diem rate that was adjusted to reflect a monthly rate.
[379] More information on other states' TCM PMPM rates is contained in Appendix C.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, average panel size for TCM services decreased by 4.15% from 149.81 utilizers per provider in CY 2018 to 143.60 utilizers per provider in CY 2019.[380] Additionally:

- In urban counties, panel size averaged 373.03 in CY 2018 and decreased to 284.06 in CY 2019.
- In rural counties, panel size averaged 34.67 in CY 2018 and increased to 35.33 in CY 2019.
- In frontier counties, panel size averaged 10.28 in CY 2018 and increased to 12.62 in CY 2019.

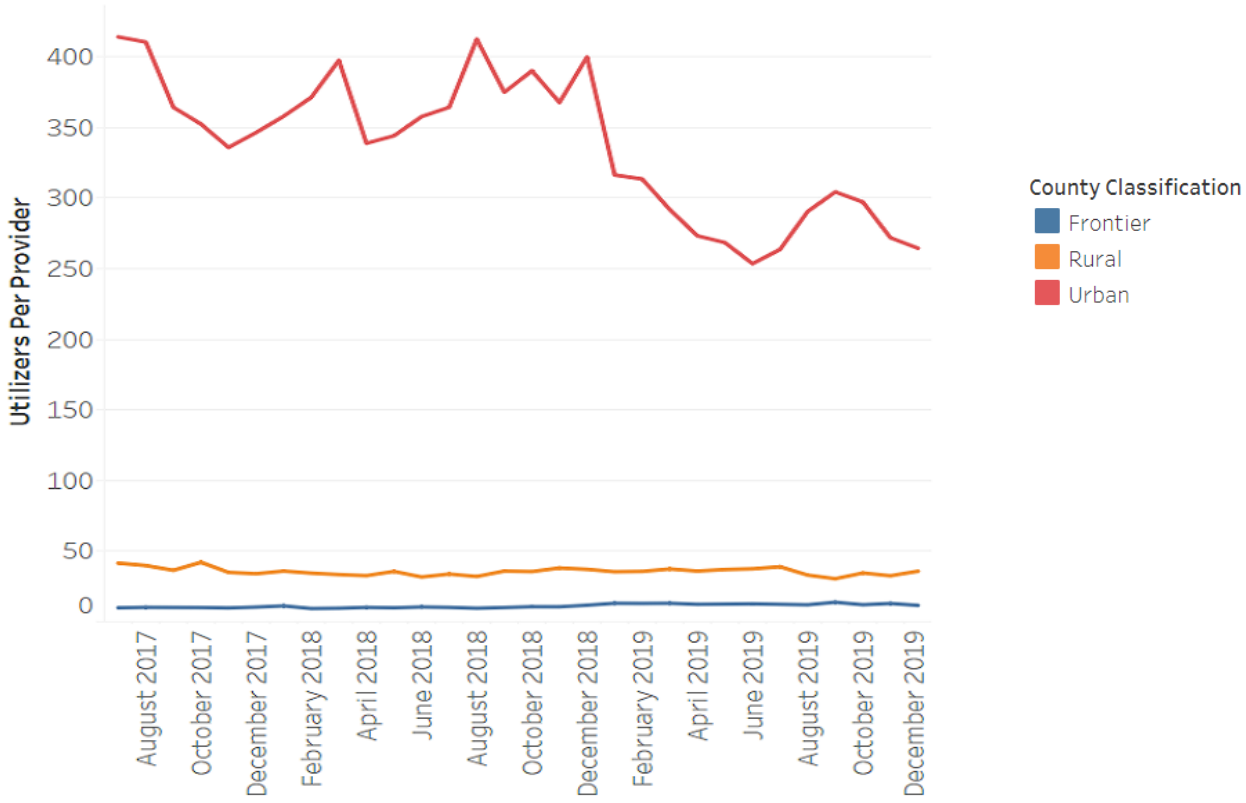

Figure 23. Utilizers per provider (panel size) for TCM services between July 2017 to December 2019.

Analysis indicates that there were increases in both the number of distinct utilizers and active providers over this time across urban county classifications.

The number of active providers increased at a greater rate than the number of distinct utilizers in urban counties over time, which led to a significant decrease in panel size over time in these counties.[381] These results indicate that, while utilization is increasing, provider availability has not been impacted.

[380] Due to changes in the Medicaid Management Information System (MMIS), data is only available from July 2017 to present.
[381] For data specific to distinct utilizer and active providers, please see Appendix E.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of TCM services reside throughout the state. Arapahoe County had the highest number of utilizers at 3,422 in CY 2019.

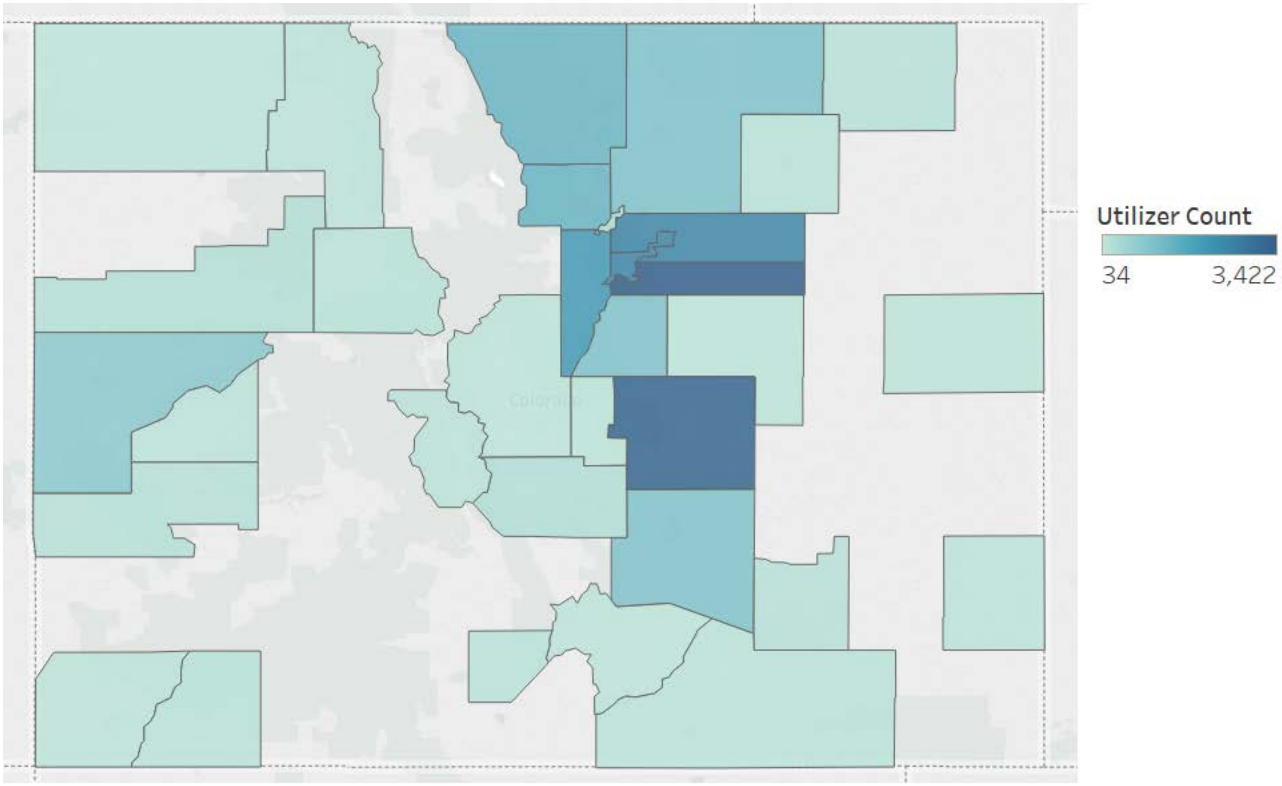

Figure 24. Utilizer density for TCM services by county for CY 2019.[382]

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

- relatively lower demand for TCM services, or a low number of Colorado Medicaid members utilizing TCM services.

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.

[382] See Figure 2. Colorado Counties and RAE County Classification on page 18 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the share of total Colorado Medicaid members in a geographic area that received the service.

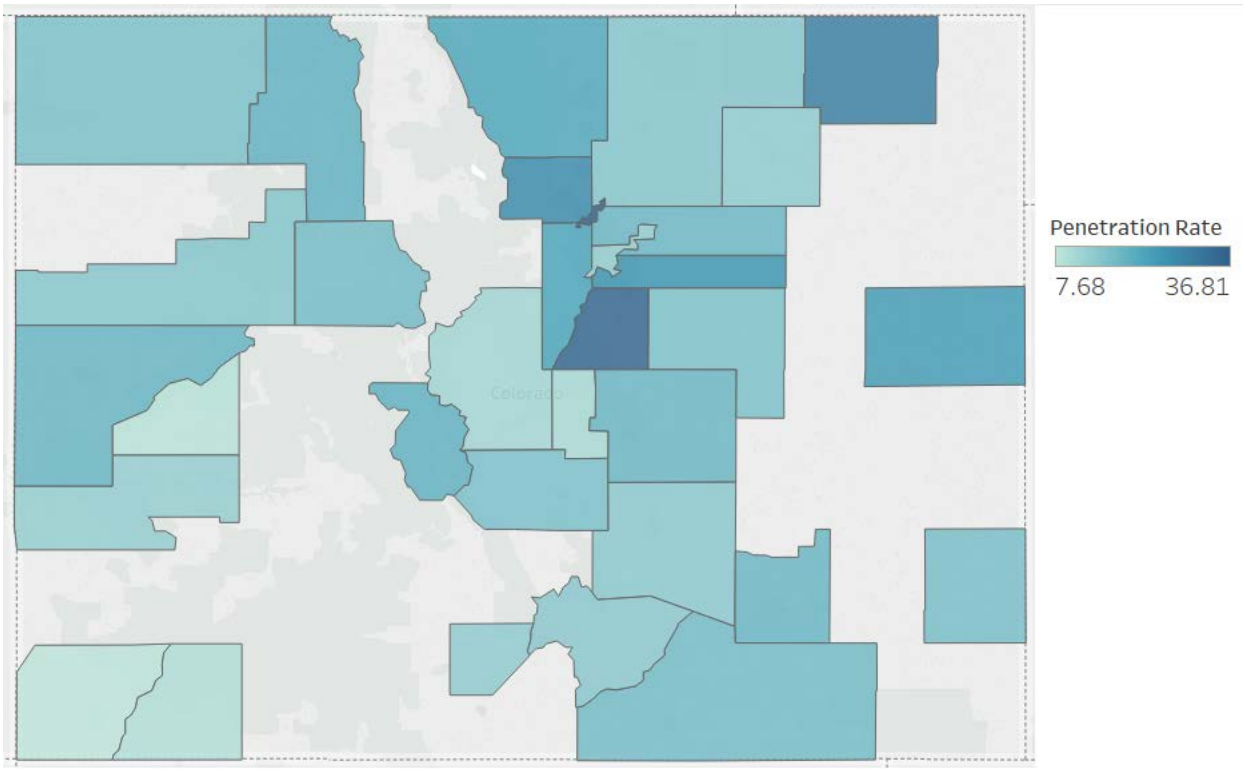

Figure 25. Penetration rates for TCM services by county in CY 2019.

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

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.

Member-to-Provider Ratios

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

TCM Member-to-Provider Ratios			
Region	**CY 2019 Service Providers**	**CY 2019 Total Colorado Medicaid Members**	**Providers per 1,000 Members**
Frontier	28	48,210	0.58
Rural	43	179,929	0.24
Urban	62	1,357,110	0.05
Statewide	**68**	**1,478,090**	**0.05**

Table 22. Member-to-provider ratio for TCM services expressed as providers per 1,000 members by county classification in CY 2019.

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.[383]

[383] Currently, the Department does not use member-to-provider ratio standards specific to TCM 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 total Colorado Medicaid members that live within certain drive time bands from where TCM services are provided.

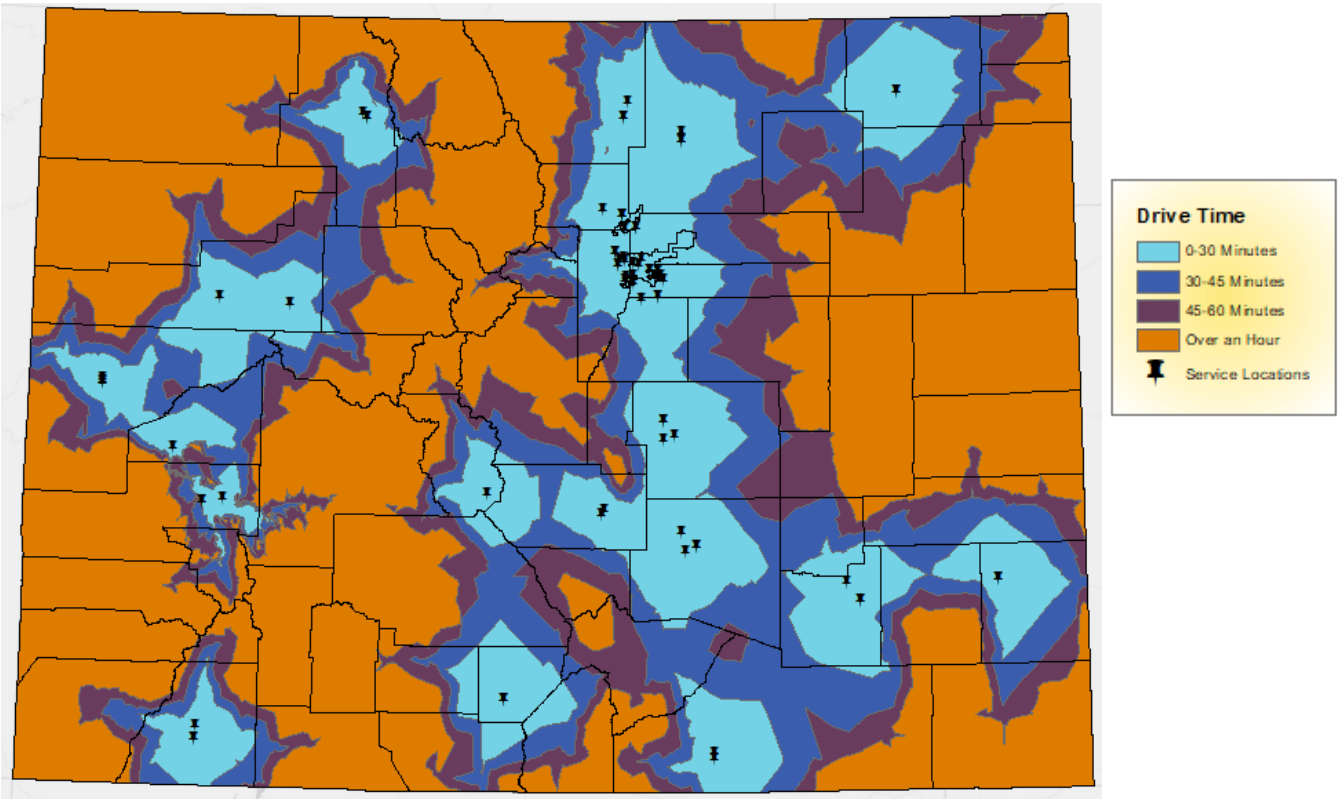

Figure 26. ArcGIS map of drive times of TCM provider service locations to total members in CY 2019.

Overall, 91.68% of total Colorado Medicaid members in CY 2019 resided 30 minutes or less from a TCM provider. Additionally, 3.07% of total members resided approximately 30-45 minutes from a TCM provider; 2.66% of total members resided 45-60 minutes from a TCM provider. Finally, 2.59% of total members resided over an hour from a TCM provider.

Stakeholder Feedback

During the MPRRAC meeting on February 5, 2021,[384] the themes that emerged from committee discussion and stakeholder feedback include:

- Benefits of conflict-free case management.[385]

Additional Considerations

Other considerations include:

- Utilization data shows an increase across all three codes, which indicates there was no impact on utilization as a result of the change to PMPM reimbursement methodology. The Department will continue to monitor utilization and provider data to ensure the change in reimbursement methodology is not impacting member access or provider retention.

Additional Research

The Department has not identified any additional research for TCM services. However, the Department will evaluate additional needs, if any, as they arise.

Conclusion

Analyses suggest TCM rates at 87.84% of the benchmark were sufficient for member access and provider retention.

The primary factors that led to this conclusion included:

- The increase in both TCM providers and utilizers over time;
- Over 94% of utilizers live within 45 minutes of a TCM service provider; and
- The Department is currently undergoing a case management redesign project to improve access to and quality of case management services.[386]

[384] The meeting recording for the MPRRAC meeting on February 5, 2021 can be found on the Medicaid Provider Rate Review Public Meetings web page.
[385] For information on Department efforts to implement conflict-free case management, see the Conflict Free Case Management web page.
[386] For more information, see the Case Management Redesign web page.

Appendices

Appendix A – Glossary

Appendix A provides explanations for common terms used in this report.

Appendix B – Transportation Services Data Analysis Methodology

Appendix B includes details of the benchmark creation, payment comparison methodology, and access to care analysis methodology for all transportation services (EMT and NEMT).

Appendix C – HCBS Waiver and TCM Data Analysis Methodology

Appendix B includes details of the benchmark creation, payment comparison methodology, and access to care analysis methodology for all HCBS Waivers and TCM.

Appendix D – CDASS Rate Analysis

Appendix D contains a modified analysis of CDASS rates conducted by the Department.

Appendix E – Service Grouping Data Books

Appendix C contains, by service grouping, the following information:

- Top procedure or revenue codes by total paid;
- Gender and age demographics;
- Scatterplots; and
- Additional access to care analysis information, including previously published access to care visuals and charts.

Appendix F – HCBS Service Groupings by Waiver

Appendix F contains details of the procedure code(s) included within each service grouping included under the HCBS Waiver and HCBS waiver services rate comparison analyses. Additional information is provided for each procedure code, including service name, rate(s), unit description, and under which waivers the service was analyzed for the purposes of this report.

Appendix G – Rate Comparison with PACE and HCBS Services

Appendix G contains a modified analysis of HCBS rates compared to PACE rates conducted by the Department.

Appendix H – OCL Stance on Direct Care Workforce

Appendix I – COVID-19 Impact on Services

Appendix J – Transportation Services Visual Data