COLORADO
Department of Health Care Policy & Financing

2024 Medicaid Provider Rate Review Analysis and Recommendation Report

November 1, 2024

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

COLORADO
Department of Health Care Policy & Financing

Contents

Executive Summary

This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder feedback, additional research, and recommendations for each service under review this year by the Medicaid Provider Rate Review Advisory Committee (MPRRAC). These services are a subset of services reviewed throughout the entire three-year cycle. For each service grouping, rate benchmark comparisons describe (as a percentage) how Colorado Medicaid payments compare to other payers, as well as anticipated fiscal impacts of recommendations, are listed below. For more information on each recommendation, please refer to the specific service category section of this report.

Benchmark Ratio and Anticipated Fiscal Impact by Service Category					
Service Category	CO as a Percent of the Benchmark	MPRRAC Recommendations - Fiscal Impact		HCPF Recommendations - Fiscal Impact	
		Total Funds	General Fund	Total Funds	General Fund
Emergency Medical Transportation (EMT)	67.08%	$12,237,729	$2,962,754	$0	$0
Non-Emergent Medical Transportation (NEMT)	52.88% - 161.78%	$13,987,037	$3,923,364	$0	$0
Qualified Residential Treatment Programs (QRTP)	49.80%	$2,640,290	$1,320,145	$0	$0
Psychiatric Residential Treatment Facilities (PRTF)	98.3%	$282,688	$141,344	$0	$0
Physician Services - Sleep Studies	121.85%	($602,660)	($200,204)	$0	$0
Physician Services - EEG Ambulatory Monitoring Codes	91.33%	$127,986	$42,517	$0	$0
Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD) Codes	70.67%	$19,181	$4,498	$0	$0
Home Health Services	70.88%	$36,305,888	$18,152,944	$0	$0
Pediatric Personal Care (PPC)	84.12%	$1,103,519	$551,760	$0	$0
Private Duty Nursing (PDN)	88.07%	$4,910,555	$2,455,278	$0	$0
Home and Community Based Services (HCBS) - All Categories	76.45%	$514,313,102	$257,156,554	$279,844	$139,922

Total	[redacted]	$585,325,315	$286,510,954	$279,844	$139,922

Table 1. Rate benchmark comparison results and anticipated fiscal impacts by service category.

Using the recommendations from the MPRRAC process, the Department of Health Care Policy and Financing (HCPF) staff prepare recommendations in accordance with anticipated budget restrictions for the coming fiscal year such as budget projections, HCPF's overall budget, and HCPF's budget relative to other state budget priorities. HCPF seriously considers the MPRRAC's recommendations when prioritizing HCPF recommendations; however, the budget allowance may not allow HCPF and MPRRAC recommendations to align. Due to the budget restraints this year, HCPF has decided to focus efforts on the rebalancing of Community First Choice (CFC) rates. For more information please refer to page 90.

The total anticipated fiscal impact of the MPRRAC's recommendations is estimated to be $585,325,315 total funds, including $286,510,954 General Fund.

The total anticipated fiscal impact of HCPF's recommendations is estimated to be $279,844 total funds, including $139,922 General Fund.

Introduction

The Colorado Department of Health Care Policy & Financing (HCPF) administers the State's public health insurance programs, including Colorado's Medicaid, Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. HCPF's 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 General Assembly adopted Senate Bill 15-228, "Medicaid Provider Rate Review," and it was amended by Senate Bill 22-236 in 2022, an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes), HCPF established a rate review process that involves three components:

- assess and, if needed, review a three-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review;
- 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 three-year schedule, provide input on reports published by HCPF, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year Two of the first three-year rate review cycle, began in March 2024 and included a general discussion of services under review and stakeholder feedback. Summaries from meetings, including presentation materials, meeting minutes, meeting schedule, previous reports, and more can be found on the HCPF website. Members of the public are encouraged to participate in the Rate Review Process; provide insight on access, quality, and provider rates; and attend meetings. Public stakeholders are invited to provide comments during the meetings on the services they represent.

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 HCPF's payment philosophy for fee-for-service (FFS) rates.

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

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., dental services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid.
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., some health education services).
4. There is a known issue with Medicare's rates (e.g., home health services).

When Medicare is not an appropriate comparator, HCPF 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 HCPF has historically viewed 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 HCPF 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 HCPF's payment philosophy, HCPF may recommend or implement a rate change. It is also important to note that HCPF may or may not recommend a change, due to the considerations listed above.

Format of Report

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

Service Description

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

- Total Adjusted Expenditures – SFY 2022-23.
- Total Members Utilizing Services – SFY 2022-23.
- Year-over-year Change in Members Utilizing Services – SFY 2022-23 – SFY 2021-22
- Total Active Providers – SFY 2022-23.
- Year-over-year Change in Active Providers – SFY 2022-23 – SFY 2021-22

Rate Comparison Analysis

HCPF 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 SFY 2022-23 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.

HCPF 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, HCPF relied upon other state Medicaid agency rates when the benchmark states have applicable fee-for-service rates for the service category. HCPF 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.

Access to Care Analysis

In evaluating access to care, HCPF utilized up to six metrics for each service category. However, some service categories did not utilize all six metrics depending on the applicability of each measure. Two of these metrics, provider participation and price-per-service, were obtained through HCPF's contract with the Center for Improving Value in Health Care (CIVHC) to assist in evaluating access. HCPF also conducted an internal access to care analysis measuring panel size, penetration rate, special providers, and telemedicine accessibility. For the purposes of this current report, the current access to care metrics do not fully capture how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurance, or to the uninsured population. HCPF and MPRRAC will explore ways to expand the access to care analysis in future review cycles.

Stakeholder Feedback

Refer to Appendix E for stakeholder feedback, which was collected from December 2023 through October 1, 2024. Stakeholders are encouraged to sign up to make a public comment during the quarterly MPRRAC meetings, as well as send in their feedback on their service(s) via email. Throughout the rate review cycle, HCPF sends the MPRRAC any stakeholder feedback that has been received so they are kept abreast of the needs of providers. The MPRRAC considers all stakeholder feedback, from public meetings and sent in via email, to inform the recommendations they make. Feedback in Appendix E is verbatim and unaltered from public stakeholders.

Additional Research

For certain service groupings and regions, particularly when HCPF's analysis indicated a potential access issue, HCPF worked to identify other data sources to conduct additional research during the MPRRAC process. Some of these data sources were

created and maintained as part of HCPF's ongoing benefit management and programmatic operations, while others were created by other organizations or State agencies. HCPF utilized these data sources to conduct further research for the 2024 Medicaid Provider Rate Review Analysis Report. Additional research included:

- 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.

- 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 HCPF's provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.

- Seeking information from the State Health Care Workforce Work team to determine the general impact of health care workforce burnout, inflation, and health care workforce shortages to understand how Medicaid reimbursement rates might have to be adjusted due to these COVID19 induced factors.

- Examining regional and statewide reports and studies published by other agencies, such as the Kaiser Family Foundation (KFF), the Home Care and Hospice Association of Colorado (HHAC), Menges Group, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Recommendations

This section lists MPRRAC's recommendations for provider rates for Year Two (Cycle One) services as a result of the Rate Review Process. Additionally, stakeholder feedback during MPRRAC meetings is helpful for identifying additional areas for evaluation. For these reasons, some recommendations focus on further research rather than direct action on rates or policy.

The report includes recommendations from HCPF in some cases. The November 1, 2024 budget proposes rate decreases for some services. The proposed budget is not discussed in this report. Information related to proposed reductions can be found in

HCPF's Legislator Resource Center[1] and complete information on the proposed budget is located on the website for the Office of State Planning and Budgeting.[2]

Limitations

Results from this report, emerging macro and micro environmental factors (i.e., inflation, health care workforce burnout, and health care workforce shortages) and additional research informed the development of HCPF 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 HCPF to quantify care that an individual may have needed but did not receive nor the provider enrollment versus providers seeing Medicaid patients. In addition, data analyses use active providers, which includes any billing or rendering provider with at least one Colorado Medicaid paid claim in a given month between July 2022 - June 2023. When HCPF evaluates other data sources, 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 all together, can help identify regions for focus.

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. 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.

[1] http://colorado.gov/hcpf/legislator-resource-center
[2] https://www.colorado.gov/governor/office-state-planning-budgeting

Emergency Medical Transportation (EMT)

Service Description

EMT services provide emergency transportation to a facility and are available to all Colorado Medicaid members.

The rates for 9 EMT codes were compared to Medicare rates, while the rates for 2 codes were compared to rates from other states and the rate for 1 code (A0021) had no benchmark data. Specifically, the rate for A0422 was compared to the rates from the following 6 states: Wisconsin, Oklahoma, Alabama, Arkansas, Montana, and California. The rate for A0225 was compared to rates from Oklahoma, Alabama, and California, and a rate-only comparison was performed due to no utilization data.

EMT Statistics	
Total Adjusted Expenditures SFY 2022-23	$ 63,518,591
Total Members Utilizing Services in SFY 2022-23	70,109
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	3.21%
Total Active Providers SFY 2022-23	332
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-3.49%

Table 2. EMT total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for EMT are estimated at 67.08% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

EMT Rate Benchmark Comparison		
Colorado Repriced	**Medicare and 6 Benchmark States Repriced**	**Rate Benchmark Comparison**
$63,518,591	$94,684,772	67.08%

Table 3. Comparison of Colorado Medicaid EMT service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $31,166,181 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 12 codes analyzed in this service grouping, the rates for 9 codes were compared to Medicare rates and the rate for 1 code was compared to the rates from 6 states. Another code was compared to three benchmark states, and it had a

rate-only comparison due to no utilization. In addition, one code, A0021, had no benchmark data and was therefore not compared. Individual rate ratios for EMT were 53.34%-86.65%.

The states chosen for the rate comparison analysis have programs that cover A0422. Wisconsin was included due to their fee-for-service model. Oklahoma, Montana, and California use a fee-for-service model and have similar geographical settings including extreme rural areas[3] along with urban and more populated areas. Alabama and Arkansas were included to facilitate a more comprehensive rate comparison. Of these states, only three, Oklahoma, Alabama, and California, had comparable rates for A0225.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the EMT panel size visual (Appendix B, Figure 1), there is an increasing trend, particularly in urban areas; this is caused by an increase in utilization. However, the provider participation visuals (Appendix B, Figures 2-3) show that the provider participation in EMT services is decreasing, and it was only 13% in 2022. Moreover, the special provider visual (Appendix B, Figure 5) shows that the percentage of providers that only serve one Medicaid member is increasing. Although Colorado Medicaid EMT rates continually increased over the past three years, Medicare paid more than twice as much as Medicaid in 2022 while the gap between commercial insurance and Medicaid was larger (Appendix B, Figure 7). This was mostly driven by the uneven proportions of out-of-network claims for different payers. These utilization, provider, and payer rate trends indicate that the access to care performance is not stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the

[3] Extreme rural areas are remote, undeveloped areas with high poverty rates and other challenges.

benchmark. The bubble chart below indicates that there are three procedure codes (A0435, A0436, and A0431) with CO rates under 60% of the benchmark rate for EMT.

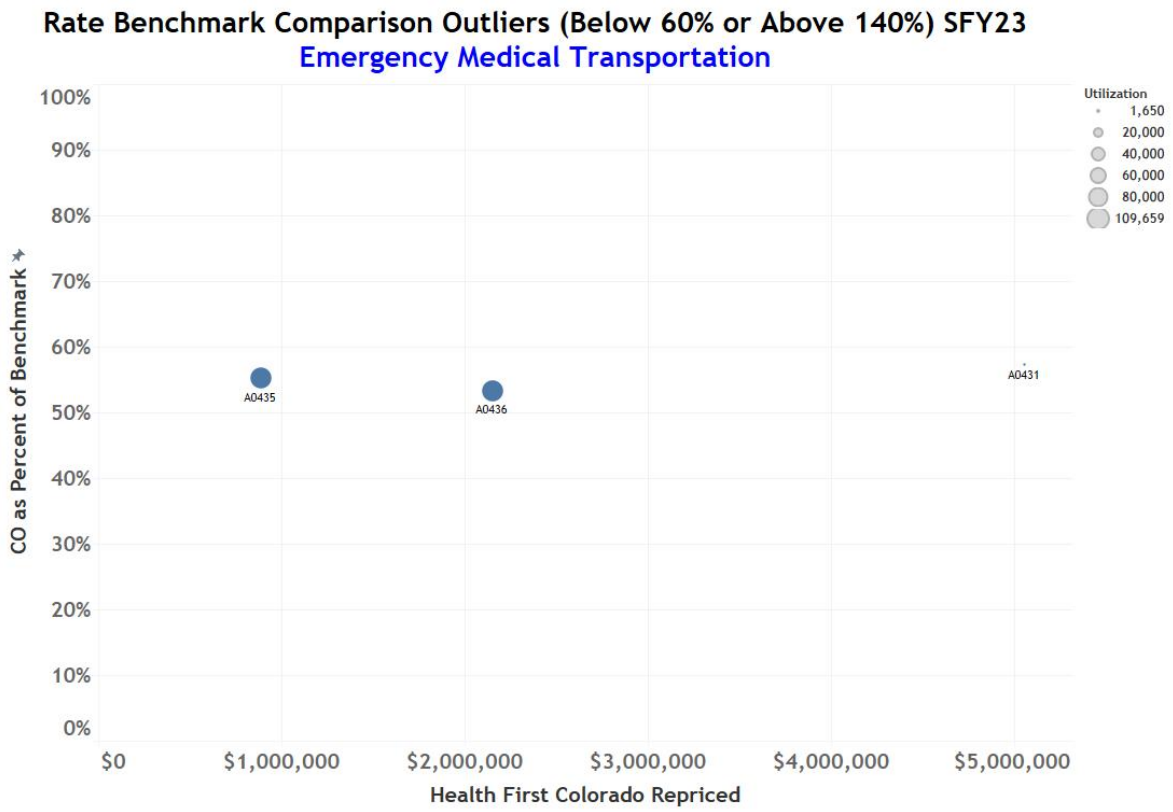


Figure 1. Bubble chart indicating the outliers under 60% found for EMT.

MPRRAC Recommendations

- The MPRRAC recommends increasing the rates for EMT codes that are under 80% of the benchmark ratio to 80% of the benchmark, and for codes with rates that are above 80% of the benchmark, the recommendation is to keep the rate the same.
- The MPRRAC recommends to match the rate of A0021, which has no benchmark ratio, with the rate of A0425.
- The MPRRAC made the following policy recommendations. Currently, there is no estimate of fiscal impact tied to these recommendations:
    - Pay for treatment in place[4], which is a medical service that involves treating patients at the scene of an emergency or in their homes instead of transporting them to a hospital;

[4] Treatment-in-place services are EMT services (basic, limited-advanced, and advanced life support services) provided by a Medicaid-enrolled EMS professional to an individual who is released on the scene

    - Explore policy modifications to pay for mobile crisis response (which incorporates telehealth) and community integrated health.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $12,237,729 total funds, including $2,962,754 General Fund.

HCPF Recommendations

- HCPF is investigating a treatment-in-place model, but is not prepared to include it in this recommendation.
- HCPF already implemented the mobile crisis response, effective on July 1, 2023.

Policy Justification

HCPF is investigating implementation options for treatment in place but is not prepared to cover it at this time due to budget constraints.

without transportation by ambulance to a medical facility. Under the current model, Medicaid-enrolled EMS professionals are not reimbursed for treatment-in-place services.

Non-Emergent Medical Transportation (NEMT)

Service Description

NEMT services provide transportation to and from Medicaid benefits and services and is available to all Medicaid members who receive full State Plan benefits.

The NEMT service grouping has 19 procedure codes. When comparing procedure codes across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

- The rates for 5 codes (A0425, A0430, A0431, A0433, and A0434) were compared to Medicare rates.
- The rates for 14 codes were compared to rates from different benchmark states. Details are listed below:

NEMT Benchmark States	
Procedure Code[5]	**Benchmark State**
A0080	Arizona and North Dakota
A0090	Arizona, Illinois, Nebraska, and New Mexico
A0120	Illinois, Nebraska, North Dakota, and Wisconsin
A0130	Alaska, Arizona, California, Nebraska, North Dakota, Oklahoma, and Wisconsin
A0180, A0200, and A0210	Alaska and New Mexico
A0190	Alaska, New Mexico, and North Dakota
A0422	Alabama, Arkansas, California, Illinois, Montana, Oklahoma, and Wisconsin
A0426 and A0428	Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Montana, New Mexico, North Dakota, Oklahoma, and Wisconsin
S0209	Arizona, Nebraska, North Dakota, Ohio, and Wisconsin
T2005	Arizona, California, Illinois, North Dakota, Oklahoma, and Wisconsin
T2049	Arizona, North Dakota, and Wisconsin

Table 4. NEMT benchmark states (SFY 2022-23).

[5] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.

Rate Comparison Analysis

Due to a significant potential risk of fraud, waste, and abuse, as well as irregularities in recent enrollments and billing by certain NEMT Medicaid providers, HCPF has recently placed hundreds of NEMT providers under prospective payment review and implemented a temporary moratorium on all new and pending NEMT provider enrollment applications. Some examples of fraudulent activities included unusually high combined expenditures with significant inappropriate billing.

As a result of the fraud investigation, the utilization data for NEMT in SFY 2022-23 is unusable. Consequently, estimating Colorado Medicaid payments is not feasible, and the average benchmark ratio cannot be calculated. Alternatively, HCPF applies the rate-only comparison method to calculate the benchmark ratio for each reviewed NEMT code. Individual rate ratios for NEMT were 52.88% - 161.78%. The rates for 2 codes were compared to the rates from 3 states. The rates for 2 codes were compared to the rates from 4 states. The rates for 14 codes were compared to the rates from different benchmark states, please refer to table 4 for details. The rates for 5 codes were compared to Medicare rates.

The states chosen for the rate comparison analysis had a Medicaid fee-for-service model for certain services under NEMT similar to Colorado. In addition, some states had similar geographical settings for members being served including extreme rural areas along with urban and more populated areas.

Access to Care Analysis

No access to care data is available for this service category due to the ongoing fraud investigation. Details can be found here.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

No additional research is available.

MPRRAC Recommendations

- The MPRRAC recommends increasing the rates of all NEMT codes under 80% of the benchmark ratio to 80% of the benchmark, and no change to the rates of codes with benchmark ratio above 80%.
- The anticipated proxy fiscal impact of the MPRRAC's recommendation based on SFY 2021-22 claim data is estimated to be $13,987,037 total funds, including $3,923,364 General Fund.

Qualified Residential Treatment Program (QRTP)

Service Description

QRTPs are facilities that provide residential trauma-informed treatment designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances. When appropriate, QRTP treatment facilitates the participation of family members, including siblings, in the child's treatment program and documents outreach to family members, including siblings. QRTP is a new service category as of 2021. Due to federal rule changes restricting the ability to reimburse RCCFs, many RCCFs transitioned into QRTPs.

The QRTP rate was compared to the rates in Iowa, North Dakota, Kansas, and Nebraska.

QRTP Statistics	
Total Adjusted Expenditures SFY 2022-23	$ 4,143,580
Average Members Utilizing Services per Month in SFY 2022-23	109
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	2%
Average Active Providers per Month in SFY 2022-23	14
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	17%

Table 5. QRTP total expenditure and utilization data (SFY 2022-23). Since QRTP services began in October 2021, the statistics were calculated as follows. The changes in members utilizing services/active providers were calculated considering the average numbers of members utilizing services/active providers per month in SFYs 2022-23 and 2021-22.

Rate Comparison Analysis

On average, Colorado Medicaid payments for QRTP are estimated at 49.80% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

QRTP Rate Benchmark Comparison		
Colorado Repriced	**4 States Repriced**	**Rate Benchmark Comparison**
$4,143,580	$8,319,687	49.80%

Table 6. Comparison of Colorado Medicaid QRTP service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $4,176,107 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. There was 1 procedure code that was compared to the rates from 4 states during SFY 2022-23.

The states chosen for the rate comparison analysis have similar geographical settings with extreme rural areas along with urban and more populated areas. Moreover, these states have comparable service definitions and program requirements as QRTPs in CO, and services are billed using a daily rate.

Access to Care Analysis

See Appendix B for the full access to care analysis.

HCPF's data for QRTP services began in October 2021. As shown in the panel size visual (Appendix B, Figure 8), since October 2021, the number of providers has increased while the number of utilizers remained almost consistent other than a spike in utilization in March and April 2022. The average number of active providers per month was 12 for SFY 2021-22 and 14 for SFY 2022-23. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

The MPRRAC requested further research into whether Oregon could be used as a benchmark state. Oregon Health Authority and HCPF both cover QRTP services on a fee-for-service basis. Neither OHA nor HCPF cover room and board under QRTP services. In Colorado, procedure code H0019 U1 is used for QRTPs, but H0019 U1 is not on the Oregon fee schedule. HCPF has one FFS rate for QRTP services of $131.33 per diem. OHA has tiered rates for behavioral rehabilitation services (BRS), including for QRTP services. These tiered rates range from $440.31 per diem to $726.05 per diem. Due to the tiered nature of OHA's rates, Oregon should be excluded from the benchmark states for QRTP.

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark. The bubble chart below indicates that the CO rate for the only QRTP procedure code is under 60% of the benchmark rate.

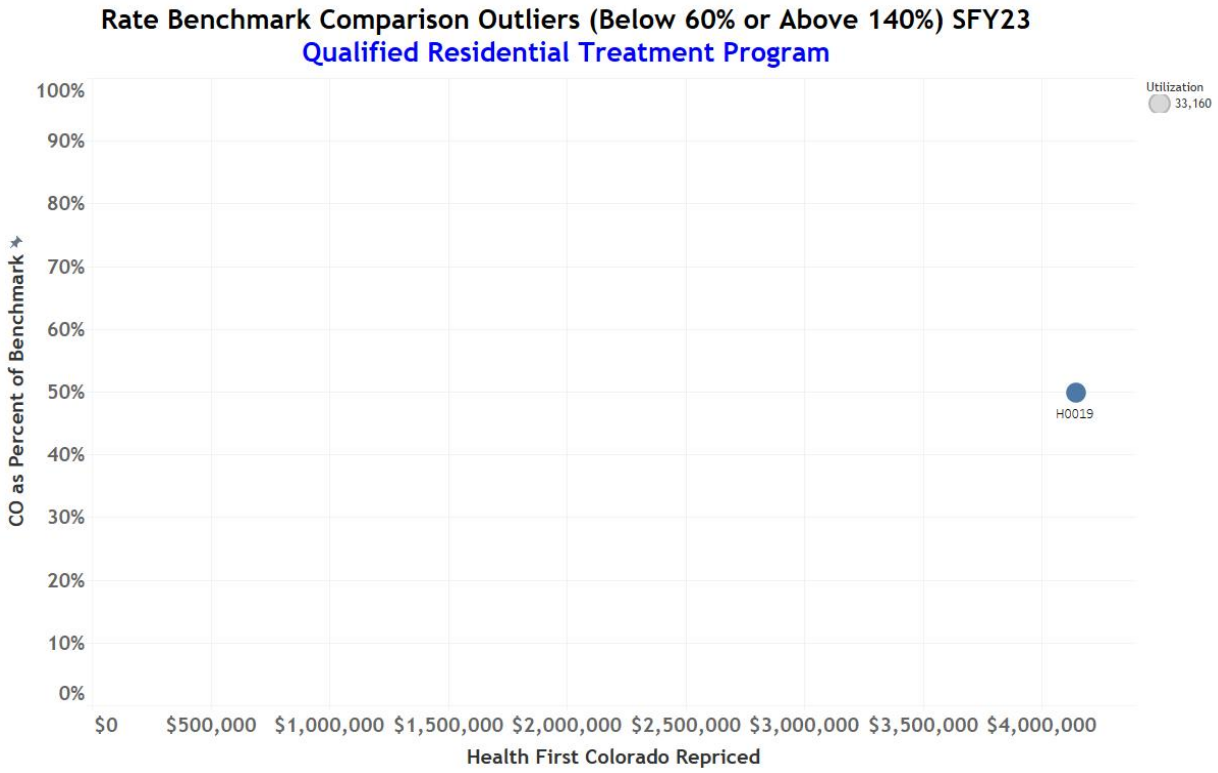


Figure 2. Bubble chart indicating the outliers under 60% found for QRTP.

MPRRAC Recommendations

- The MPRRAC recommends increasing the QRTP rate to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $2,640,290 total funds, including $1,320,145 General Fund.

Psychiatric Residential Treatment Facilities (PRTF)

Service Description

PRTFs provide comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or severe emotional disturbance, need treatment that can most effectively be provided in a residential treatment facility. PRTF services are provided under the direction of a physician.

The PRTF rate was compared to the rates in Arizona, Georgia, Ohio, Oklahoma, Oregon, and Washington.

PRTF Statistics	
Total Adjusted Expenditures SFY 2022-23	$ 15,591,064
Total Members Utilizing Services in SFY 2022-23	184
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	201.64%
Total Active Providers SFY 2022-23	22
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-4.35%

Table 7. PRTF total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for PRTF are estimated at 98.3% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

PRTF Rate Benchmark Comparison		
Colorado Repriced	**6 States Repriced**	**Rate Benchmark Comparison**
$ 15,591,064	$ 15,860,034	98.3%

Table 8. Comparison of Colorado Medicaid PRTF service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $268,970 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. There was 1 revenue code that was compared to the rates from 6 states during SFY 2022-23.

The states chosen for the rate comparison analysis have comparable service definitions and program requirements as PRFTs in CO. Georgia uses a fee-for-service billing model, and the other states have similar geographical settings with extreme rural areas along with urban and more populated areas.

Access to Care Analysis

See Appendix B for the full access to care analysis.

The out-of-state placement rate for PRTF services was 40% due to a lack of in-state providers for hard-to-serve populations. The panel size visual (Appendix B, Figure 10) shows substantial increases in panel size in rural and urban areas, this is a result of a more than 200% increase in utilization from SFY 2021-22 to SFY 2022-23. However, the total number of active providers decreased from 23 in SFY 2021-22 to 22 in SFY 2022-23. Moreover, while the price per service (Appendix B, Figure 14) paid by Medicaid underwent a 62% increase from 2021 to 2022, the Medicaid price per service (Appendix B, Figure 15) was only 53% of that paid by commercial insurance, as shown by the payer rate visual. These utilization, provider, and payer rate trends indicate that the access to care performance is not stable in this service area.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

No additional research is available.

MPRRAC Recommendations

- The MPRRAC recommends increasing the PRTF rate to 100% of the benchmark.
- For members whose diagnoses are classified as high acuity, the MPRRAC recommends increasing the PRTF rate to 120% of the benchmark. Currently, there is no fiscal impact attached to this recommendation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $282,688 total funds, including $141,344 General Fund.

HCPF Recommendations

- HCPF recommends delaying the recommendation to increase the rates for members whose diagnoses are classified as high acuity to 120% of the benchmark.

Policy Justification

HCPF recommends delaying an increase to high-acuity PRTF rates until HCPF can complete an actuarial analysis of the current rate this fiscal year, as required by House Bill 24-1038. This bill requires HCPF to evaluate its reimbursement rate for psychiatric residential treatment facilities using an actuarial analysis from a third-party vendor. The estimated timeline for this actuarial analysis is July 2025. HCPF believes it should not increase these rates ahead of the analysis.

Physician Services - Sleep Studies

Service Description

Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with six or more hours of recording with physician review, interpretation and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging. Sleep studies and polysomnography are typically provided by hospitals, clinics, independent laboratories, or Independent Diagnostic Testing Facilities (IDTF). IDTFs enroll with Colorado Medicaid as Provider Type 16 (Clinic) or Provider Type 25 (Non-physician practitioner - group). Sleep studies and polysomnography fall under Physician Services and are available, as medically necessary, to all Medicaid members who receive full State Plan benefits.

Sleep Studies Statistics	
Total Adjusted Expenditures SFY 2022-23	$3,523,786
Total Members Utilizing Services in SFY 2022-23	12,713
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	8.07%
Total Active Providers SFY 2022-23	176
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	8.64%

Table 9. Sleep studies total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for sleep studies are estimated at 121.85% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below. Sleep studies services were compared to Medicare.

Sleep Studies Rate Benchmark Comparison		
Colorado Repriced	**Medicare Repriced**	**Rate Benchmark Comparison**
$ 3,523,786	$ 2,892,008	121.85%

Table 10. Comparison of Colorado Medicaid sleep studies service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact to Colorado Medicaid would be ($631,778) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 36 procedure codes / modifiers analyzed in this service grouping, 27 were compared to

Medicare (75%), 3 procedure code/modifier combinations (G0399, G0399-TC, and G0399-26) did not have applicable benchmark (Medicare) rates, 6 procedure codes/modifier combinations (95783-TC, 95801-TC, 95803-TC, 95807, 95807-TC, and 95808) did not have valid utilization during SFY 2022-23 and thus, underwent a benchmark rate-only comparison. Individual rate ratios for sleep studies were 28.14%-239.20%.

Access to Care Analysis

See Appendix B for the full access to care analysis.

While Colorado Medicaid sleep study rates are higher than Medicare rates, provider participation remains low at 11%. The overall rates for sleep study services in Colorado have increased over the past five years (Figure 5 below). Although a low percentage (9%-11%) of providers served Medicaid members in the sleep studies service category statewide from 2020 to 2022, as seen in the provider participation visuals (Appendix B, Figures 17-18), there is still a slight upward trend. Moreover, as observed in the sleep studies panel size visual (Appendix B, Figure 16), the number of members utilizing sleep study services decreased by 22% between August and December 2022, particularly in urban areas. However, this decline was temporary, as utilization rates rebounded to previous levels by January 2023. During the same period (August to December 2022), the provider count for sleep studies services remained stable. Overall, despite temporary fluctuations, member utilization and provider participation in the sleep studies service category have remained steady.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view data on the outliers for each service category. Outliers are identified as rates that are under 60% or above 140% of the benchmark. The bubble chart below indicates that Colorado rates for sleep studies procedure codes/modifiers 95806, 95806-26, and 95806-TC are above 140% of the benchmark.

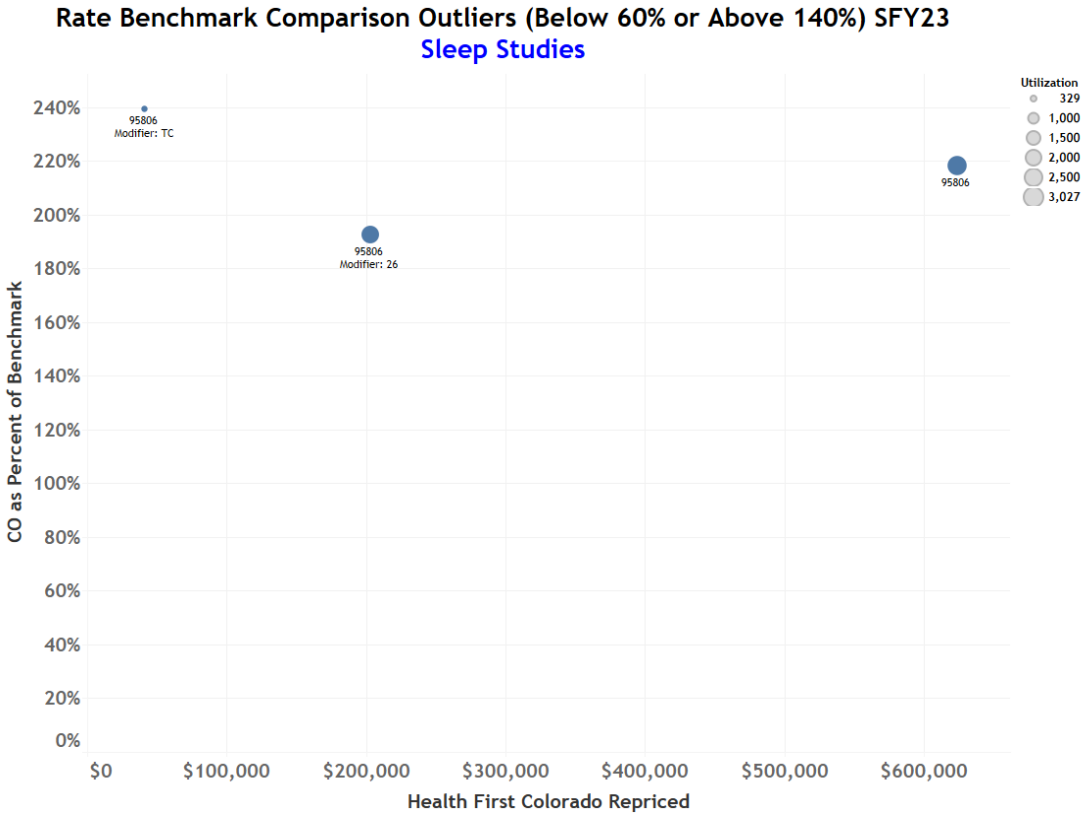


Figure 3. Bubble chart indicating the outliers under 60% and over 140% found for sleep studies.

The MPRRAC also requested an explanation for the elevated overall benchmark ratio in the sleep studies service category. The accompanying charts illustrate the average year-over-year reimbursement rate percentage changes across all procedure codes and modifiers for both Medicare and Colorado Medicaid. Between 2020 and 2024, Medicare reimbursement rates for sleep studies declined by 5.84% (Figure 4). In contrast, Colorado Medicaid rates increased by 6.61% during the same period (Figure 5). As a result, the overall benchmark ratio, which is calculated by dividing the Colorado rate by the Medicare rate, is high.

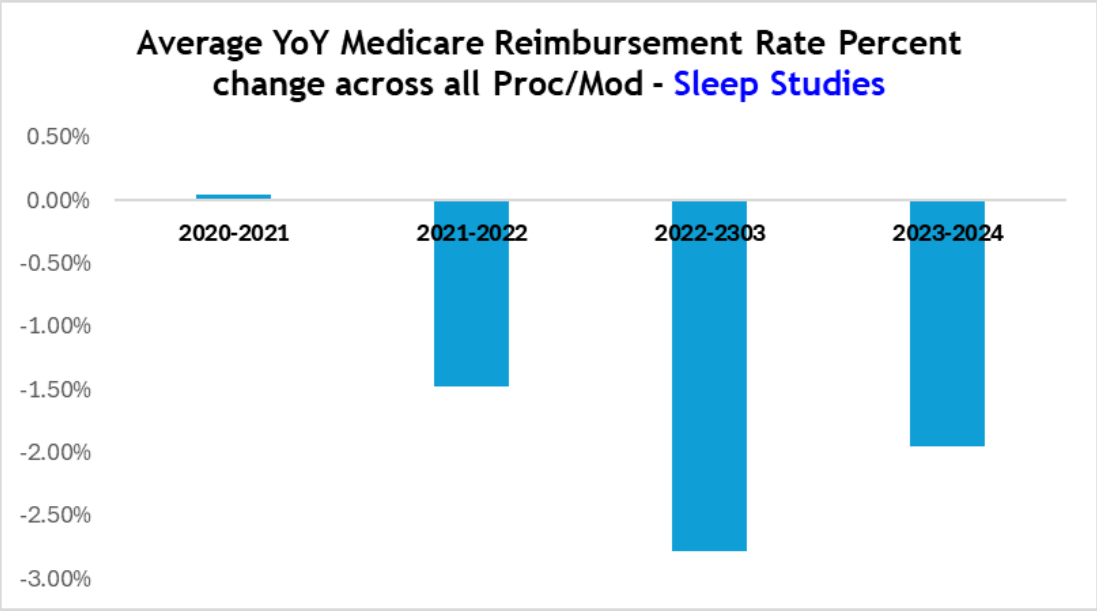


Figure 4. Bar chart indicating the average year-over-year sleep studies reimbursement rate percentage changes for Medicare.

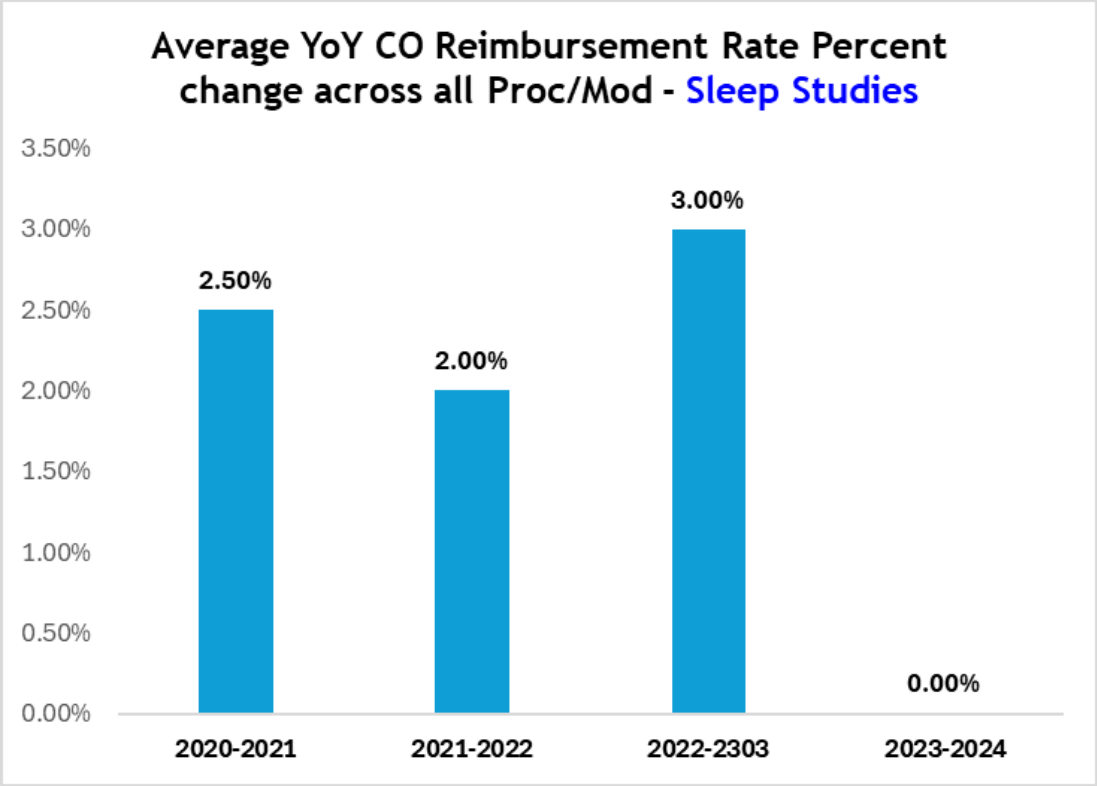


Figure 5. Bar chart indicating the average year-over-year sleep studies reimbursement rate percentage changes for Colorado Medicaid.

MPRRAC Recommendations

- The MPRRAC recommends adjusting the rates for all codes with a current benchmark ratio below 80% to 80% of the benchmark, while reducing the rates for all codes with a current benchmark ratio above 80% to 80% of the benchmark.
- For cost-saving purposes, the MPRRAC recommends keeping the rates for unattended (home-based) codes unchanged.
- The MPRRAC proposes setting the rate for G0399, which lacks a benchmark ratio, to be comparable to the rates for G0398 and G0400.
- The anticipated fiscal impact of MPRRAC's recommendations is estimated to be ($602,660) total funds, including ($200,204) General Fund.

Physician Services - EEG Ambulatory Monitoring

Service Description

Electroencephalogram (EEG) is a test that measures the electrical activity in the brain using small, metal discs. EEGs can help diagnose brain disorders, especially epilepsy or other seizure disorders. Ambulatory EEG monitoring is an EEG that is recorded at home. Ambulatory EEGs are typically provided by hospitals, clinics, or Independent Diagnostic Testing Facilities (IDTF). IDTFs enroll with Colorado Medicaid as a clinic or a group of non-physician practitioners. Ambulatory EEGs fall under Physician Services and are available, as medically necessary, to all Medicaid members who receive full State Plan benefits.

The EEG ambulatory monitoring rates were compared to Medicare rates.

EEG Ambulatory Monitoring Statistics	
Total Adjusted Expenditures SFY 2022-23	$ 2,472,339
Total Members Utilizing Services in SFY 2022-23	2,801
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	9.97%
Total Active Providers SFY 2022-23	113
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	3.67%

Table 11. EEG ambulatory monitoring total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for EGG ambulatory monitoring are estimated at 91.33% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

EEG Ambulatory Monitoring Rate Benchmark Comparison		
Colorado Repriced	**Medicaid Repriced**	**Rate Benchmark Comparison**
$ 2,472,339	$ 2,707,036	91.33%

Table 12. Comparison of Colorado Medicaid EEG ambulatory monitoring service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact to Colorado Medicaid would be $234,697 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 23 procedure codes analyzed in this service grouping, 19 were compared to Medicare (82.6%) during SFY 2022-23. A rate-only comparison was performed for the 4 other

procedure codes because there was no utilization data. Individual rate ratios for EEG ambulatory monitoring were 48.18%-334.66%.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As shown by the provider participation visuals (Appendix B, Figures 22-23), provider participation in Medicaid EEG ambulatory monitoring services decreased by 28% from 2020 to 2022. The statewide provider participation rate for EEG ambulatory monitoring in 2022 was 32%. Moreover, the special providers visual (Appendix B, Figure 25) shows that the percent of active providers that serve only one Medicaid member remained around 20% during state fiscal years 2021-2023 for EEG ambulatory monitoring services. These provider trends could indicate that access to care for members is not stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark. The bubble chart below indicates that there is one procedure code (95715) with CO rates under 60% of the benchmark rate and two procedure codes (95708 and 95714) with CO rates over 140% of the benchmark rate for EEG ambulatory monitoring.

Figure 6. Bubble chart indicating the outliers under 60% and over 140% found for EEG ambulatory monitoring.

MPRRAC Recommendations

- The MPRRAC recommends decreasing the rates for EEG ambulatory monitoring codes 95708 and 95714 to 100% of the benchmark and increasing the rate for code 95715 to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $127,986 total funds, including $42,517 General Fund.

FFS Behavioral Health Substance Use Disorder (FFS BH SUD)

Service Description

Substance use disorder (SUD) coverage includes the continuum of care services delivered in accordance with ASAM (American Society of Addiction Medicine) criteria. This continuum includes preventative care, outpatient care, high intensity outpatient care, residential care and inpatient hospital care. Medication Assisted Treatment (MAT) and Screening and Assessments.

The FFS BH SUD service grouping consists of 7 procedure codes. Rates for FFS BH SUD services were compared to the rates from the following 5 states and 1 district: Maryland, Massachusetts, Missouri, Ohio, Washington (State), and Washington D.C. Procedure code S9445 was removed from the analysis because there was no benchmark rate and H0010 was removed due to zero utilization in SFY 2023.

When comparing procedure codes across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

- 1 code (S9445) did not have benchmark state data.
- 1 code (H0010) did not have utilization in SFY 2023.
- The rates for 5 codes were compared to the rates from different benchmark states. Details are listed below:

FFS BH SUD Benchmark State	
Procedure Code[6]	**Benchmark State**
H0001, H0005, H0020	Maryland, Massachusetts, Missouri, Ohio, Washington (State), Washington D.C
H0004	Maryland, Massachusetts, Missouri, Ohio, Washington (State)
H0006	Massachusetts, Ohio, Washington (State), Washington D.C.

Table 13. FFS BH SUD Benchmark States (SFY 2022-23).

A summary of the statistics for the FFS BH SUD service category is provided below.

FFS BH SUD Statistics	
Total Adjusted Expenditures SFY 2022-23	$ 87,648
Total Members Utilizing Services in SFY 2022-23	330
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	-17.29%
Total Active Providers SFY 2022-23	39
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-27.78%

[6] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.

Table 14. FFS BH SUD total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS BH SUD are estimated at 70.67% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below. FFS BH SUD services were compared to the rates from 5 other states and Washington D.C.

FFS BH SUD Rate Benchmark Comparison		
Colorado Repriced	**D.C. and 5 Other States Repriced**	**Rate Benchmark Comparison**
$87,648	$124,031	70.67%

Table 15. Comparison of Colorado Medicaid FFS BH SUD service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after cost of living adjustment to Colorado Medicaid would be $36,383 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 7 procedure codes/modifiers analyzed in this service grouping, the rates for 5 codes were compared to 5 states and Washington D.C. (71.4%), 1 code (H0010) didn't have utilization in SFY 2023, and 1 code (S9445) did not have a benchmark rate. Individual rate ratios for FFS BH SUD were 44.29% - 108.22%.

Massachusetts, Maryland, Missouri, Washington (state), Ohio, and Washington D.C. were selected for benchmark comparison because their SUD procedure codes and service descriptions were comparable to Colorado's, with some shared combination of similar prices, program requirements, and/or rate structures that stipulate payment on either a fee-for-service basis or to an MCO.

Access to Care Analysis

See Appendix B for the full access to care analysis.

While the present analysis focuses on BH SUD services that are reimbursed on a fee-for-service (FFS) basis, the majority of Health First Colorado members receive BH SUD services through their assigned regional accountable entity (RAE) as part of capitated behavioral health programming. Therefore, FFS BH SUD services account for the minority of utilization and expenditures related to substance use disorder services in Colorado.

As seen in the FFS BH SUD panel size visual (Appendix B, Figure 28), there were notable fluctuations across SFY 2021 - SFY 2023. This was most pronounced among

urban regions, and to a lesser degree rural regions, where fluctuations were a result of shifts in the number of active providers and utilizers month-to-month. Additionally, the penetration rate visuals (Appendix B, Figure 29) show that members in 23 of Colorado's 64 counties utilized services in this category, with the most utilization per 1000 members having occurred in Pueblo County, where approximately 2.1 out of 1000 Medicaid members utilized this service.

The telemedicine visual (Appendix B, Figure 30) shows that the percentage of individual members that utilized telemedicine services among FFS BH SUD utilizers increased slightly before decreasing across SFY 2021 - SFY 2023. Additionally, the percentage of total visits that were delivered through telemedicine (Appendix B, Figure 31) decreased before increasing across SFY 2021 - SFY 2023, even though the amount of total visits, including those that were telemedicine, increased as a whole before decreasing.

In conclusion, month-to-month fluctuations occurred among active providers rendering FFS BH SUD services, as well as shifts in utilizer counts. However, because the vast majority of SUD services are delivered by RAE's through capitated programming, these shifts are not thought to have a significant impact on access to SUD services. Additionally, the utilization of FFS BH SUD services is more likely serving a functional purpose of filling a gap for members not attributed to RAE's.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

No additional research is available.

MPRRAC Recommendations

- For regular codes with benchmark ratio, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, while advising no change to the rates of codes already above 80%.
- For codes without benchmark ratio (S9445), the MPRRAC recommends to increase its rate to be proportional to the overall recommendation (i.e., 9.33%).
- The anticipated fiscal impact of the MPRRAC's recommendations is estimated to be $19,181 total funds, including $4,498 General Fund.

Home Health (HH) Services

Service Description

Home health services consist of skilled nursing, certified nurse aide (CNA) services, physical (PT) and occupational therapy (OT) services and speech/language pathology (SLP) services. Home health services are a mandatory State Plan benefit offered to Colorado Medicaid members who need intermittent skilled care. Providers that render home health services must be employed by a class A licensed home health agency. Home health services are provided in home and community settings.

The HH service grouping has 20 revenue code/modifier combinations. When comparing revenue code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

- 2 codes (599 and 780 with no modifiers) did not have benchmark state data.
- 2 codes (583 with no modifiers and 780 with modifier TG) only had very limited utilization data and no benchmark state data.
- 1 code (583 with modifier TG) had no utilization data and no benchmark state data.
- The rates for 15 codes were compared to the rates from different benchmark states. Details are listed below:

HH Benchmark States	
Revenue Code[7]	**Benchmark State**
420, 421, 430, and 431	Idaho, Illinois, Louisiana, North Carolina, Nebraska, Ohio, and Washington
424, and 434	Illinois, Louisiana, and North Carolina
440, 441, 570, and 571	Idaho, Illinois, Louisiana, North Carolina, Nebraska, Ohio, Washington, and Wisconsin
550, and 551	Idaho, Illinois, North Carolina, Nebraska, Ohio, and Washington
572, and 579	Louisiana and Nebraska
590	Washington

Table 16. HH Benchmark States (SFY 2022-23).

A summary of the statistics for the HH service category is provided below.

[7] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.

HH Statistics	
Total Adjusted Expenditures SFY 2022-23	$599,566,595
Total Members Utilizing Services in SFY 2022-23	31,036
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	5.60%
Total Active Providers SFY 2022-23	201
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-3.83%

Table 17. HH total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HH are estimated at 70.88% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HH Rate Benchmark Comparison		
Colorado Repriced	**8 Other States Repriced**	**Rate Benchmark Comparison**
$592,132,057	$835,352,952	70.88%

Table 18. Comparison of Colorado Medicaid HH service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $243,220,895 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 20 revenue codes/modifiers analyzed in this service grouping, rates for 15 codes were compared to the rates from up to 8 states. 2 codes did not have benchmark state data. 2 codes/modifiers only had very limited utilization data and no benchmark state data. 1 code/modifier did not have utilization data nor benchmark state data during SFY 2022-23. Individual rate ratios for HH were 58.1% - 251.2%.

The states chosen for the rate comparison analysis either had similar geographical settings for members being served including extreme rural areas along with urban and more populated areas. Otherwise, the state had comparable service definitions and program requirements under HH, with rate structures on a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

The number of active providers for the HH service group has slightly dropped for the past three state fiscal years. The panel size visual (Appendix B, Figure 32) shows that in urban areas, the number of utilizers per provider has a noticeable increase. This is due to a large increase in member enrollment. For both frontier and rural areas, this metric remained stable over the same period.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark. The bubble chart below indicates that there are two revenue codes (570 and 571), with CO rates under 60% of the benchmark rate for HH.

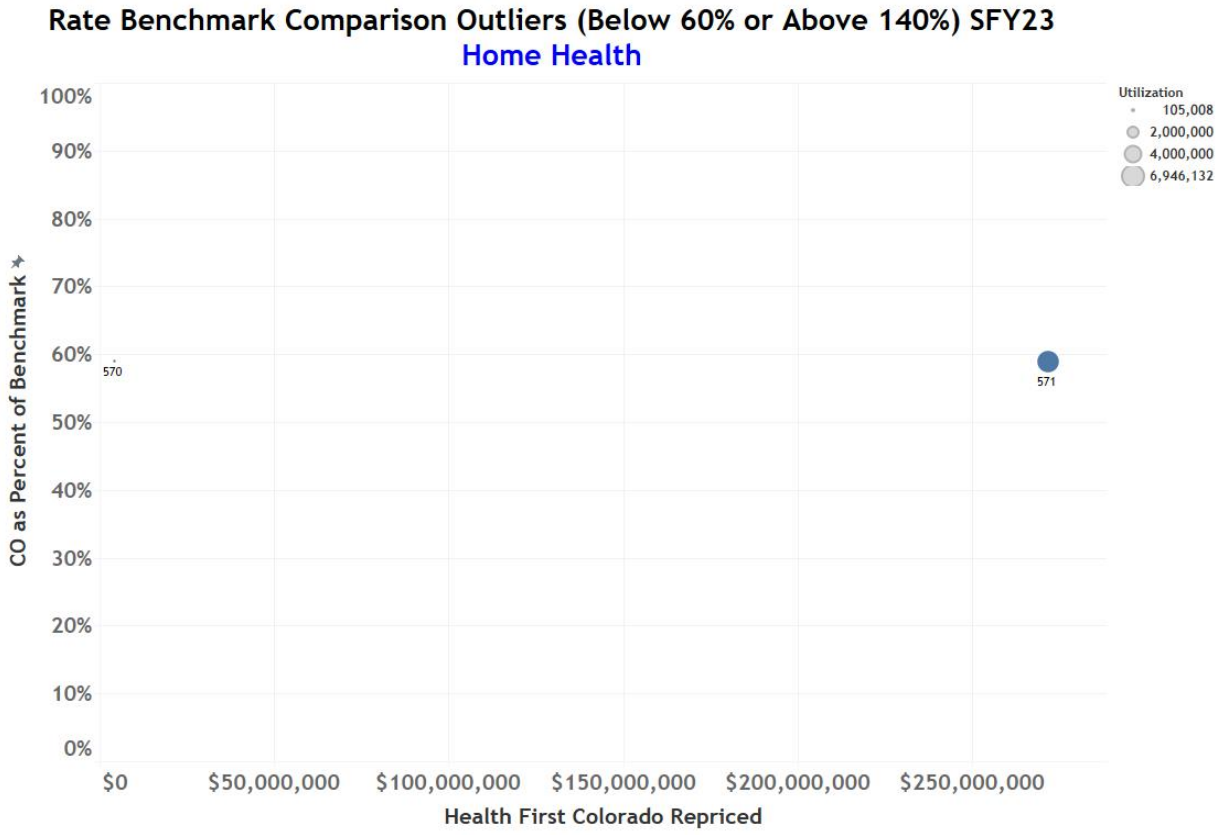


Figure 7. Bubble chart indicating the outliers under 60% and over 140% found for HH.

MPRRAC Recommendations

- The MPRRAC recommends increasing the overall benchmark ratio for HH from 71% to 75%, allowing HCPF to decide which codes to prioritize for the greatest impact on access to care. However, this increase does not apply to the rates of codes with benchmark ratios already above 100%.
- The MPRRAC recommends increasing the rates for codes without a benchmark by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $36,305,888 total funds, including $18,152,944 General Fund.

Pediatric Personal Care (PPC)

Service Description

PPC services consist of 17 personal care tasks performed by a non-medically trained caregiver for children ages 0-20 and provided in the member's home. The PPC benefit was implemented in October 2015. PPC services are the lowest level of care in the home health care continuum for children. Colorado is one of three states that provides pediatric personal care services outside of waiver benefits.

The PPC service grouping has only one procedure code T1019. This code has different rates for inside Denver county and for outside of Denver county; both rates were compared to the rates from the following 6 states: Arizona, Nevada, Pennsylvania, Utah, Washington, and Wisconsin.

PPC Statistics	
Total Adjusted Expenditures SFY 2022-23	$4,210,831
Total Members Utilizing Services in SFY 2022-23	177
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	-5.35%
Total Active Providers SFY 2022-23	7
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	0%

Table 19. PPC total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for PPC are estimated at 84.12% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

PPC Rate Benchmark Comparison		
Colorado Repriced	**6 Other States Repriced**	**Rate Benchmark Comparison**
$4,210,831	$5,005,563	84.12%

Table 20. Comparison of Colorado Medicaid PPC service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $794,732 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. The procedure code analyzed in this service grouping was compared to an average of six other states' Medicaid rates. Individual rate ratios for PPC (outside or inside Denver) were 82.12% - 88.70%.

The states chosen for the rate comparison analysis had Medicaid fee-for-service models for PPC services similar to Colorado. In addition, most of the states had similar geographical settings for members being served including extreme rural areas along with urban and more populated areas.

Access to Care Analysis

See Appendix B for the full access to care analysis.

The PPC service category's access to care results demonstrate a positive outcome. The panel size visual (Appendix B, Figure 38) shows that in urban areas, despite notable fluctuations from month to month due to the limited number of providers, which ranged from 5 to 7, there has been an upward trend in the number of members per provider utilizing this service over the past three state fiscal years. In contrast, the utilizers per provider rate for both frontier and rural areas remained constant. The statewide provider participation rate (Appendix B, Figure 40) remained stable from 2020 to 2022, consistently ranging between 99% and 100%.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

No additional research is available.

MPRRAC Recommendations

- The MPRRAC recommends aligning the rates for identical services between PPC and HCBS Community First Choice and selecting the higher rate of two rates for PPC.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $1,103,519 total funds, including $551,760 General Fund.

Private Duty Nursing (PDN)

Service Description

PDN services consist of continuous skilled nursing care provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for Colorado Medicaid members who are dependent on medical technology. PDN services are meant to provide care to members who need a higher level of care than is available in the home health benefit. PDN services are performed by an RN or LPN in the member's home. The PDN benefit is an optional benefit provided through Medicaid agencies; Colorado is one of 25 states that reimburses for PDN services.

The PDN service grouping has 5 revenue codes. When comparing revenue codes across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

- The rates for 2 codes (552 and 559) were compared to the rates from the following 7 states: California, Illinois, Louisiana, North Carolina, Nebraska, Washington, and Massachusetts.
- The rates for 3 codes (580, 581, and 582) were compared to the rates from the following 4 states: Louisiana, North Carolina, Washington, and Massachusetts.

A summary of the statistics for the PDN service category is provided below.

PDN Statistics	
Total Adjusted Expenditures SFY 2022-23	$99,824,124
Total Members Utilizing Services in SFY 2022-23	832
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	-4.91%
Total Active Providers SFY 2022-23	34
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	0.00%

Table 21. PDN total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for PDN are estimated at 88.07% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

PDN Rate Benchmark Comparison		
Colorado Repriced	7 Other States Repriced	Rate Benchmark Comparison
$99,824,124	$113,350,320	88.07%

Table 22. Comparison of Colorado Medicaid PDN service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $13,526,196 Total Funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 5 codes analyzed in this service grouping, the rates for 2 codes were compared to the rates from 7 states, and the rates for 3 codes were compared to the rates from 4 states. Individual rate ratios for PDN were 68.57% - 95.09%.

Most of the states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, most of these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

The number of active providers for the PDN service group has remained stable for the last three state fiscal years. As seen in the panel size visual (Appendix B, Figure 42), both frontier and rural areas maintained a steady number of members utilizing this service during this timeframe. In contrast, urban areas have exhibited a constantly decreasing trend in utilization over the same period. The statewide provider participation rate (Appendix B, Figure 44) remained relatively stable from 2020 to 2022, consistently ranging between 21% and 23%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

In Colorado's Medicaid, PDN services are billed using revenue codes. Consequently, HCPF's review for this service utilizes revenue codes to align with the fee schedule. The Home Care and Hospice Association of Colorado expressed concerns regarding

HCPF's methodology of matching Colorado's revenue codes to Healthcare Common Procedure Coding System (HCPCS) codes used in benchmark states, as HCPCS is the standard for reporting procedures and services to health insurance programs in other states. In response to these concerns, HCPF has provided additional clarification on the process of correlating Colorado's revenue codes with HCPCS codes in benchmark states, and subsequently, how the benchmark ratio was calculated for each revenue code. For a comprehensive explanation of the PDN cross-work of benchmark states, please refer to Appendix D.

MPRRAC Recommendations

- The MPRRAC recommends increasing the rates for PDN revenue codes 552 and 559 to 100% of benchmark, while advising no change to the rates of the other three revenue codes.
- If possible, use the PDN HCPCS codes for the benchmark comparison analysis in the future. This is a review process recommendation instead of policy recommendation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be $4,910,555 total funds, including $2,455,278 General Fund.

Home & Community Based Services - ADL Assistance and Delivery Models

Service Description

This service provides personal assistance in personal functional activities required by an individual for continued wellbeing which are essential for health and safety, such as help with bathing, dressing, toileting, eating, housekeeping, meal preparation, laundry, and shopping.

- Homemaker (Basic/Enhanced/Remote Supports)
- In Home Support Services (Health Maintenance/Homemaker/Personal Care/Relative Personal Care)
- Personal Care
- Personal Care (Relative/Remote Supports)
- Consumer Directed Attendant Support Services (CDASS)
- Medication Reminder
- Respite
- Protective Oversight

The rates for HCBS ADL assistance and delivery models were compared to rates in Connecticut, Illinois, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Utah and Wisconsin.

HCBS - ADL Statistics	
Total Adjusted Expenditures SFY 2022-23	$528,069,550
Total Members Utilizing Services in SFY 2022-23	28,036
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	6.31%
Total Active Providers SFY 2022-23	495
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-3.51%

Table 23. HCBS ADL assistance and delivery models total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS –ADL assistance and delivery models are estimated at 64.81% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS - ADL Rate Benchmark Comparison		
Colorado Repriced	**9 States Repriced**	**Rate Benchmark Comparison**
$528,069,550	$814,856,292	64.81%

Table 24. Comparison of Colorado Medicaid *HCBS ADL* assistance and delivery models service *payments to those of other payers, expressed as a percentage (SFY 2022-23).*

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $286,786,742 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-23. Of the 72 procedure code/modifier/county/waiver program combinations analyzed in this service group, 52 of them (72.22%) were compared to rates from 9 other states, and 20 of them (27.78%) did not have benchmark state data. Individual rate ratios for HCBS ADL assistance and delivery models were 46.73% - 103.94%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 46), the number of utilizers per provider for the HCBS ADL assistance and delivery models service category has been steadily increasing over the last three state fiscal years. The statewide provider participation rate (Appendix B, Figure 48) remained relatively stable from 2020 to 2022, consistently ranging between 99% and 100%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes ranked by utilization for each service category. The table below ranks the procedure codes with the highest utilization for HCBS ADL assistance and delivery models. These codes

represent 97.99% of the codes with a benchmark with utilization for this service category and is made up of three procedure codes that have unique modifiers for each specific waivers (HCBS - CHCBS, HCBS - DD, HCBS - EBD, and HCBS - SLS) and the geography (Denver County, Outside of Denver county).

	HCBS - ADL Top 10 Procedure Codes by Utilization				
Rank	**Code + Modifier[8]**	**Service Description**	**Benchmark Ratio**	**Utilization[9]**	**% of Total Utilization**
1	T1019U1	Personal Care	87.0%	23,037,500	31.27%
2	H0038U5	In Home Support Services, Health Maintenance	46.7%	17,078,218	23.18%
3	H0038U1	In Home Support Services, Health Maintenance	57.3%	13,062,489	17.73%
4	S5130U1KX	In Home Support Services, Homemaker	87.5%	5,743,403	7.80%
5	S5130U1	Homemaker, Basic	92.2%	4,444,896	6.03%
6	T1019U1KX	In Home Support Services, Personal Care	80.8%	4,425,431	6.01%
7	T1019U8	Personal Care	91.8%	1,558,403	2.12%
8	T1019UA	Personal Care	87.3%	1,446,383	1.96%

[8] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[9] Utilization refers to the total number of service units utilized for each specific procedure code.

9	S5130U8	Homemaker, Basic	81.4%	696,953	0.95%
10	S5130UA	Homemaker, Basic	92.9%	694,598	0.94%

Table 25. HCBS ADL assistance and delivery models top 10 procedure codes ranked by utilization.

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below indicates there are six data points for procedure code H0038, associated with waiver programs HCBS - EBD, HCBS - CIH and HCBS - CHCBS both in and outside Denver county, falling under 60% of the benchmark.

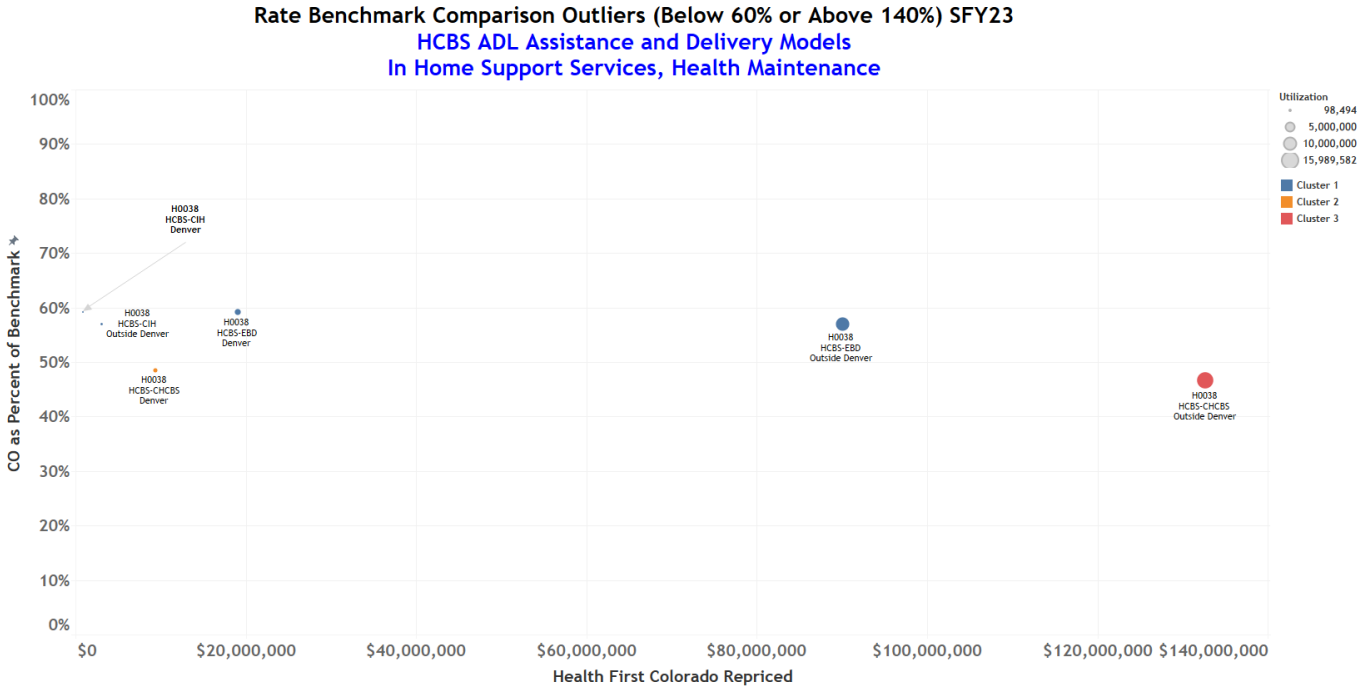


Figure 8. Bubble chart indicating the outliers under 60% found for HCBS ADL assistance and delivery models (H0038).

Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Behavioral Services

Service Description

These services provide assistance to people with a mental illness or who need behavior support and require long-term support and services in order to remain in a community setting. This includes assessment, behavior support plans, and interventions.

- Behavioral Plan Assessment
- Behavioral Services
- Behavioral Services (Consultation/Counseling/Counseling Group/Line Staff)
- Peer Mentorship
- Consumer Directed Attendant Support Services (CDASS)
- Mental Health Counseling
- Substance Use Counseling

The rates for HCBS behavioral services were compared to rates in Connecticut, Montana, North Dakota, and Oklahoma.

HCBS Behavioral Services Statistics	
Total Adjusted Expenditures SFY 2022-23	$3,608,285
Total Members Utilizing Services in SFY 2022-23	3,079
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	2.26%
Total Active Providers SFY 2022-23	104
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-21.21%

Table 26. HCBS behavioral services total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS behavioral services are estimated at 124.09% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Behavioral Services Rate Benchmark Comparison		
Colorado Repriced	**5 States Repriced**	**Rate Benchmark Comparison**
$3,608,285	$2,907,801	124.09%

Table 27. Comparison of Colorado Medicaid HCBS behavioral services *service payments to those of other payers, expressed as a percentage (SFY 2022-23).*

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($700,484) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 11 procedure code/modifier/county/waiver program combinations

analyzed in this service group, 7 (63.64%) of them were compared to the rates from 4 other states and 4 (36.36%) of them did not have benchmark data. Individual rate ratios for HCBS behavioral services were between 35.30% - 295.07%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 50), the number of utilizers per provider for the HCBS behavioral services category has been steadily increasing over the last two state fiscal years. The statewide provider participation rate (Appendix B, Figure 52) had a slight drop from 97% in 2020 to 95% in 2022. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The chart below ranks the procedure codes with the highest utilization for HCBS behavioral services. These codes represent 100% of the utilization for this service category and are made up of two procedure codes that have unique modifiers for three specific waivers (HCBS - CES, HCBS - DD, and HCBS - SLS).

	HCBS Behavioral Services Procedure Codes by Utilization				
Rank	**Code + Modifier[10]**	**Service Description**	**Benchmark Ratio**	**Utilization [11]**	**% of Total Utilization**

[10] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[11] Utilization refers to the total number of service units utilized for each specific procedure code.

1	H2019U322TG	Behavioral Services, Behavioral Consultation	295.1%	95,297	44.68%
2	H2019U3	Behavioral Services, Behavioral Line Staff	41.6%	85,246	39.97%
3	H2019U8	Behavioral Services, Behavioral Line Staff	41.6%	11,730	5.50%
4	H2019U822TG	Behavioral Services, Behavioral Consultation	295.0%	11,694	5.48%
5	H2019U3TFHQ	Behavioral Services, Behavioral Counseling Group	35.3%	6,768	3.17%
6	H2019U8TFHQ	Behavioral Services, Behavioral Counseling Group	35.3%	1,299	0.61%
7	H0025U6	Behavioral Services	66.9%	1,262	0.59%

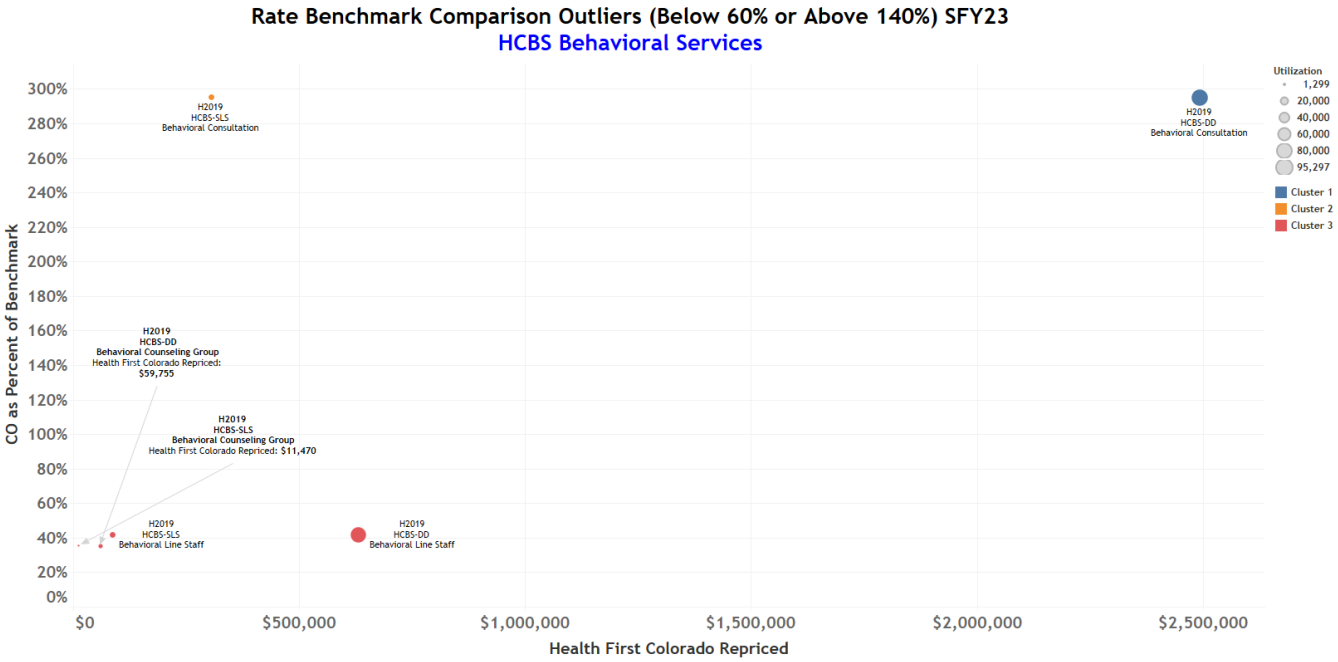
Table 28. HCBS behavioral services had only 7 codes with utilization and an applicable rate comparison.

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below indicates that there are six data points for procedure code H2019, associated with the waiver programs HCBS-SLS and HCBS-DD, that exceed 140% of the benchmark. Each waiver program has three data points that cover "Behavioral Line Staff" service, "Behavioral Counseling Group" service and "Behavioral Consultation" service.

Figure 9. Bubble chart indicating the outliers under 60% and over 140% found for HCBS behavioral services (H2019).



Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Community Access and Integration

Service Description

These services ensure that HCBS participants have access to the benefits of community living and live and receive services in integrated, non-institutional settings.

- Adult Day Service Transportation (Mileage/Mobility Van/Taxi/Wheelchair Van)
- Benefits Planning
- Case Management
- Child and Youth Mentorship (Intensive/Transition Support Services)
- Community Connector
- Independent Living Skills Training
- Life Skills Training
- Mentorship
- Non Medical Transportation, (Mileage/Mobility Van/Taxi/Wheelchair Van/Other)
- Parent Education
- Prevention and Monitoring Intensive/Transition Support Services
- Supported Employment, Job Coaching (Group/Individual)
- Supported Employment, Job Development (Group/Individual)
- Supported Employment, Job Placement (Group/Individual)
- Supported Employment, Workplace Assistance
- Wraparound Plan Intensive/Transition Support Services
- Residential Habilitation Services and Supports (RHSS)
- Individual Residential Services and Supports (IRSS)
- Group Residential Services and Supports (GRSS)
- Supported Living Program (SLP)

The rates for HCBS community access and integration services were compared to rates in Connecticut, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Utah.

HCBS Community Access and Integration Statistics	
Total Adjusted Expenditures SFY 2022-23	$39,618,121
Total Members Utilizing Services in SFY 2022-23	20,649
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	5.58%
Total Active Providers SFY 2022-23	548
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-0.36%

Table 29. HCBS community access and integration total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS community access and integration are estimated at 156.37% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Community Access and Integration Rate Benchmark Comparison		
Colorado Repriced	**7 States Repriced**	**Rate Benchmark Comparison**
$39,618,121	$25,336,432	156.37%

Table 30. Comparison of Colorado Medicaid HCBS community access and integration service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($14,281,689) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 262 code/modifier/county/waiver program combinations analyzed in this service group, 92 (35.12%) of them were compared to the rates from 8 other states, 8 (3.05%) of them used case-by-case negotiated rate instead of a fixed rate, and 162 (61.83%) of them did not have benchmark state data. Individual rate ratios for HCBS community access and integration were between 7.48% – 394.09%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 54), the number of utilizers per provider for the HCBS community access and integration category has been steadily increasing over the last three state fiscal years. The statewide provider participation rate (Appendix B, Figure 56) remained relatively stable from 2020 to 2022, consistently ranging between 99% and 100%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure codes with the highest utilization for HCBS community access and integration. These codes represent 74.01% of the utilization for this service category and is made up of four procedure codes that have unique modifiers for each specific waivers (HCBS - CHCBS, HCBS - EBD, an HCBS - SLS) and the geography (Denver County, Outside of Denver county).

	HCBS Community Access and Integration Top 10 Procedure Codes by Utilization				
Rank	**Code + [12]Modifier**	**Service Description**	**Benchmark Ratio**	**Utilization [13]**	**% of Total Utilization**
1	T2003U322	Non-Medical Transportation, Mileage Band 2 (11-20 Miles)	372.6%	393,171	14.22%
2	A0120U1HB	Adult Day Service Transportation, Mobility Van Mileage Band 1 (0-10 Miles)	119.6%	307,559	11.13%
3	T2019U322HQ	Supported Employment, Job Coaching Group, Level 2	135.1%	238,857	8.64%
4	T2019U3TGHQ	Supported Employment, Job Coaching Group, Level 5	86.4%	196,721	7.12%
5	T2003U3TF	Non-Medical Transportation, Mileage Band (Over 20 Miles)	253.5%	181,858	6.58%
6	T1016U5	Case Management	53.8%	177,714	6.43%

[12] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[13] Utilization refers to the total number of service units utilized for each specific procedure code.

7	A0120U1HBHX	Adult Day Service Transportation, Mobility Van Mileage Band 1 (0-10 Miles)	126.9%	160,667	5.81%
8	T2019U3TFHQ	Supported Employment, Job Coaching Group, Level 3	185.5%	147,374	5.33%
9	T2019U3TF22HQ	Supported Employment, Job Coaching Group, Level 4	113.2%	131,144	4.74%
10	T2003U822	Non Medical Transportation, Mileage Band 2 (11-20 Miles)	372.6%	110,911	4.01%

Table 31. Top 10 Procedure codes by utilization

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below indicates that there are three data points for procedure code H2023, associated with the waiver programs HCBS-SLS (outside Denver county) and HCBS-DD (both Denver and outside Denver county), falling under 60% of the benchmark.

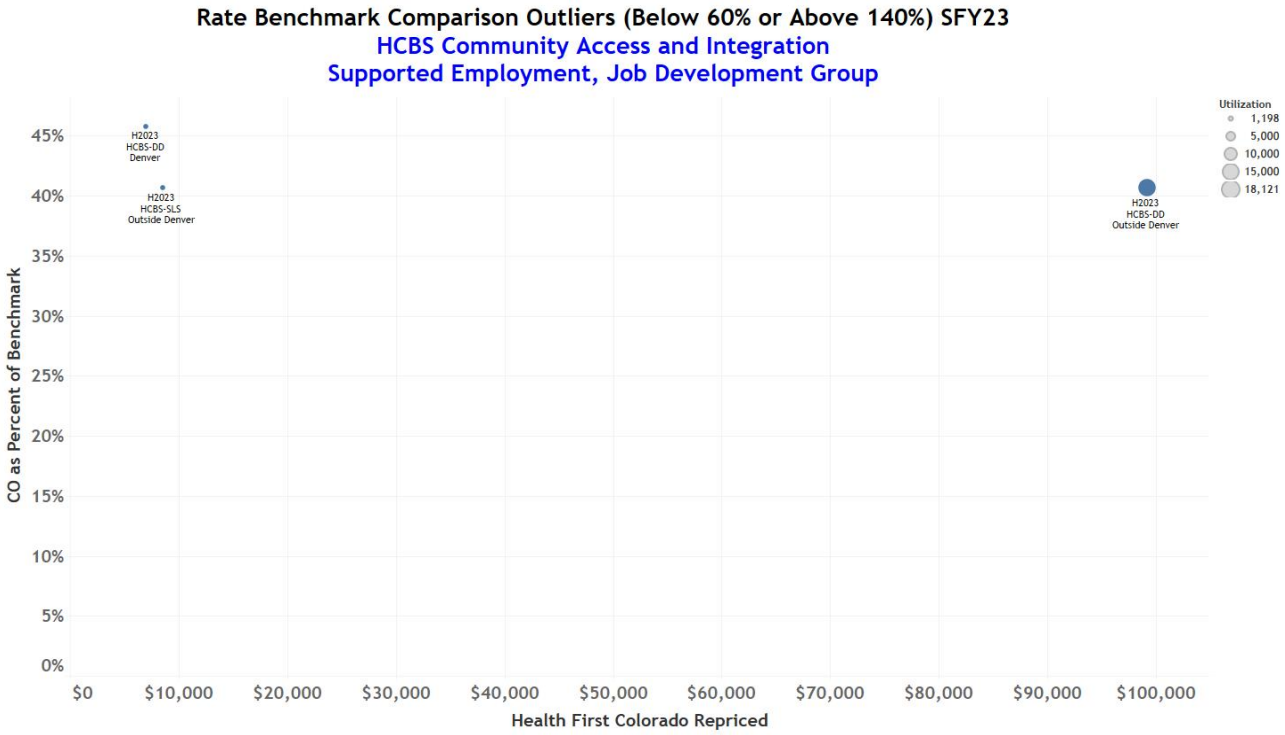


Figure 10. Bubble chart indicating the outliers under 60% found for HCBS community access and integration (H2023).

The bubble chart below indicates that there are two data points for procedure code H2024, associated with the waiver programs HCBS-SLS and HCBS-DD, falling under 60% of the benchmark.

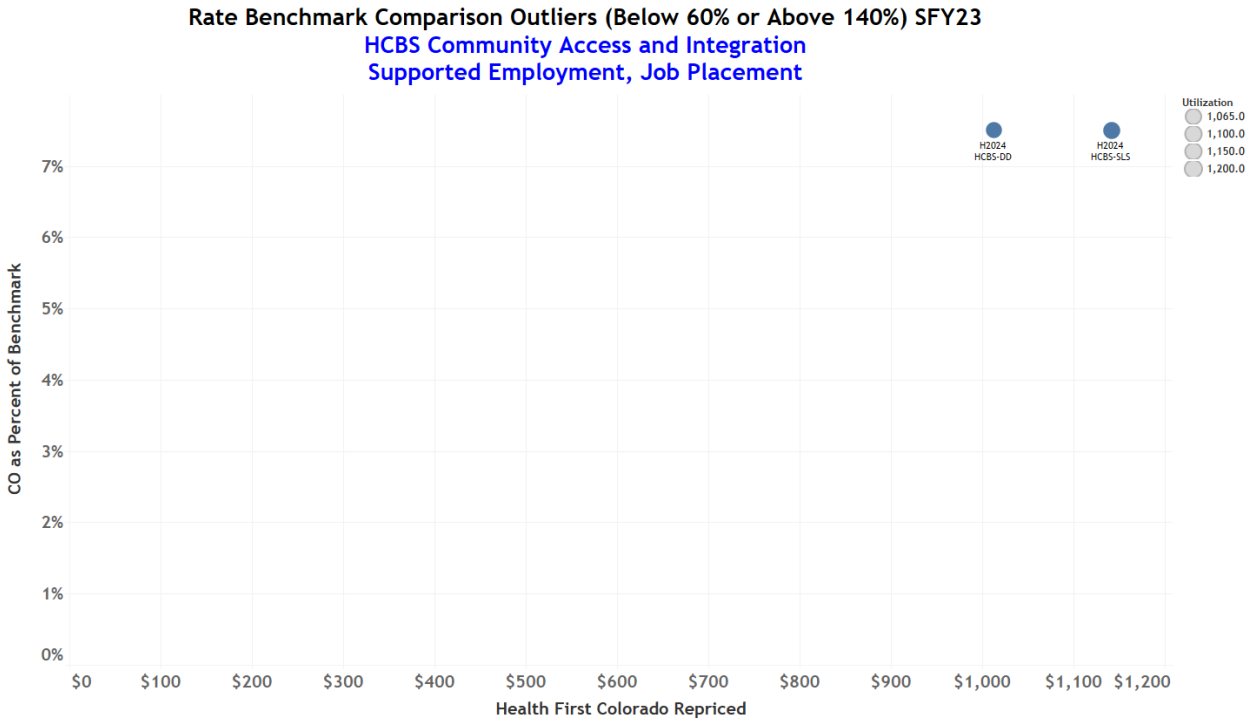


Figure 11. Bubble Chart indicating the outliers under 60% found for HCBS community access and integration (H2024)

The bubble chart below indicates that there is one data point for procedure code T1016, associated with the waiver program HCBS-CHCBS, falling under 60% of the benchmark.

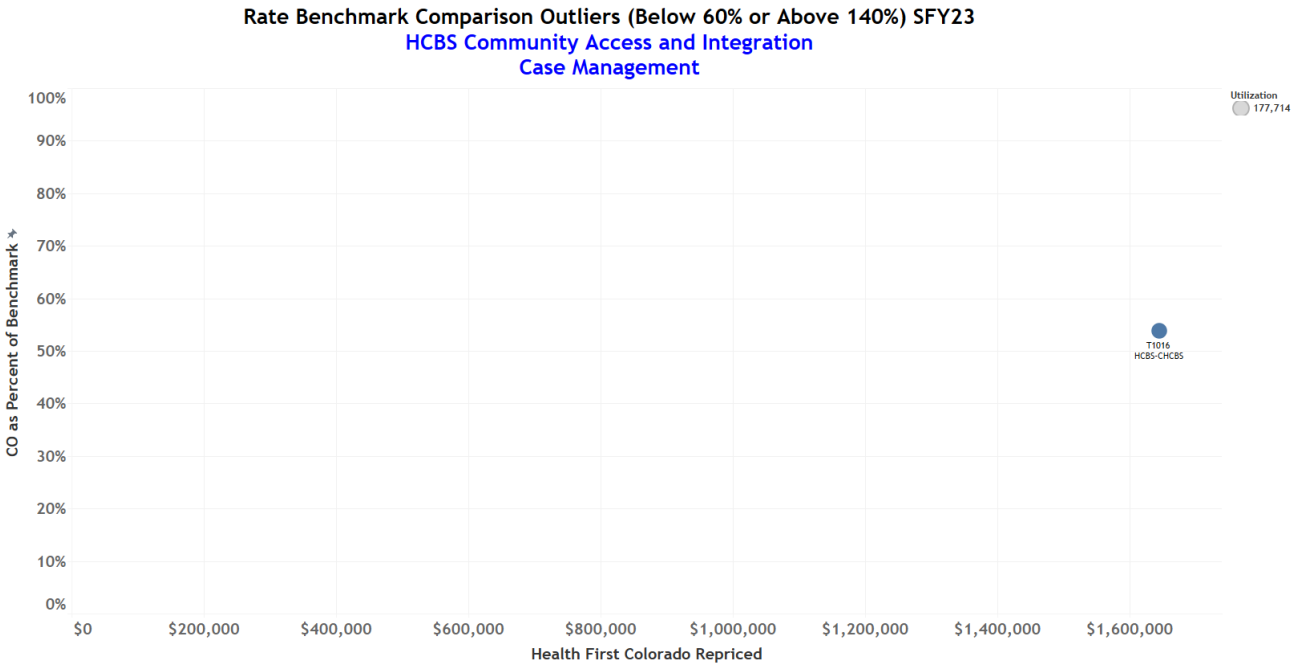


Figure 12. Bubble chart indicating the outliers under 60% found for HCBS community access and integration (T1016).

The bubble chart below shows eight data points for procedure code T2003, associated with the waiver programs HCBS-SLS and HCBS-DD, exceeding 140% of the benchmark. Each waiver program has four data points that cover mileage bands of 11-20 miles and more than 20 miles, for both in and outside Denver county.

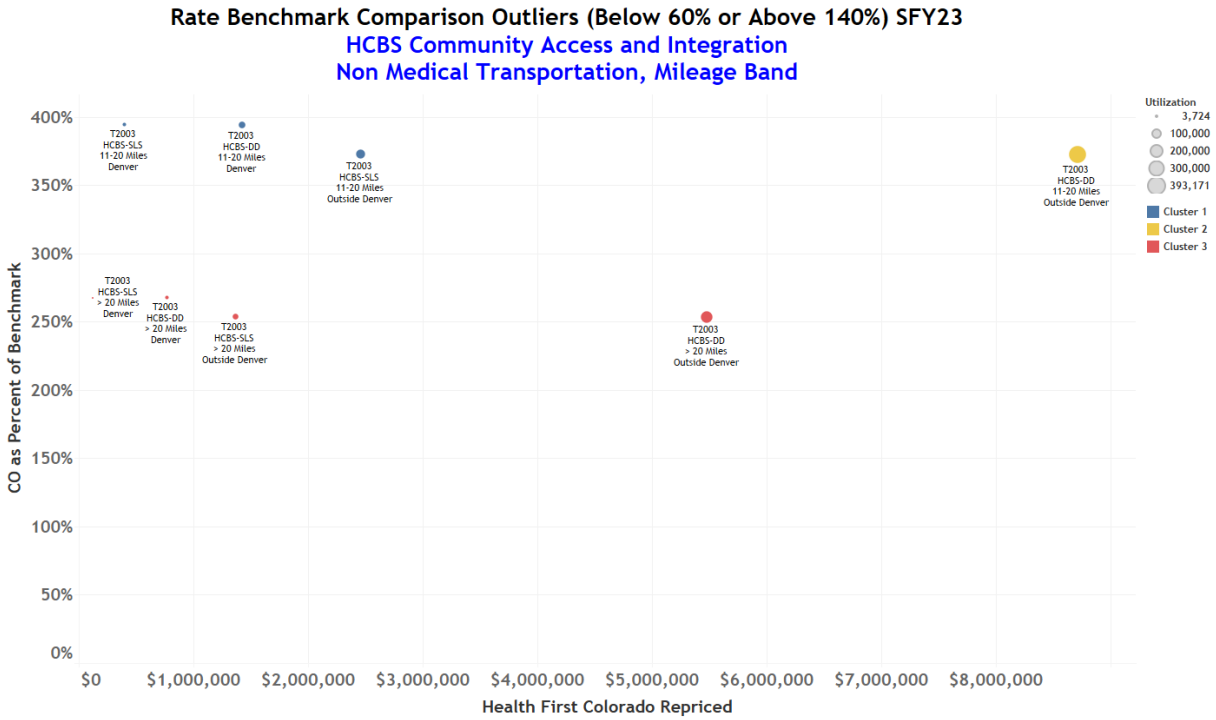


Figure 13. Bubble Chart indicating the outliers over 140% found for HCBS community access and integration (T2003)

The bubble chart below shows eight data points for procedure code T2019 associated with the waiver programs HCBS-SLS and HCBS-DD. Two data points linked to both waiver programs with service description "Supported Employment, Job Coaching Group, Level 1" in Denver County are under 60% of the benchmark. Another two data points, also linked to both waiver programs with service description "Supported Employment, Job Coaching Group, Level 2" in Denver County, exceed 140% of the benchmark. The remaining four data points linked to both waiver programs with service description "Supported Employment, Job Coaching Group, Level 3", both within and outside Denver County, are above 140% of the benchmark.

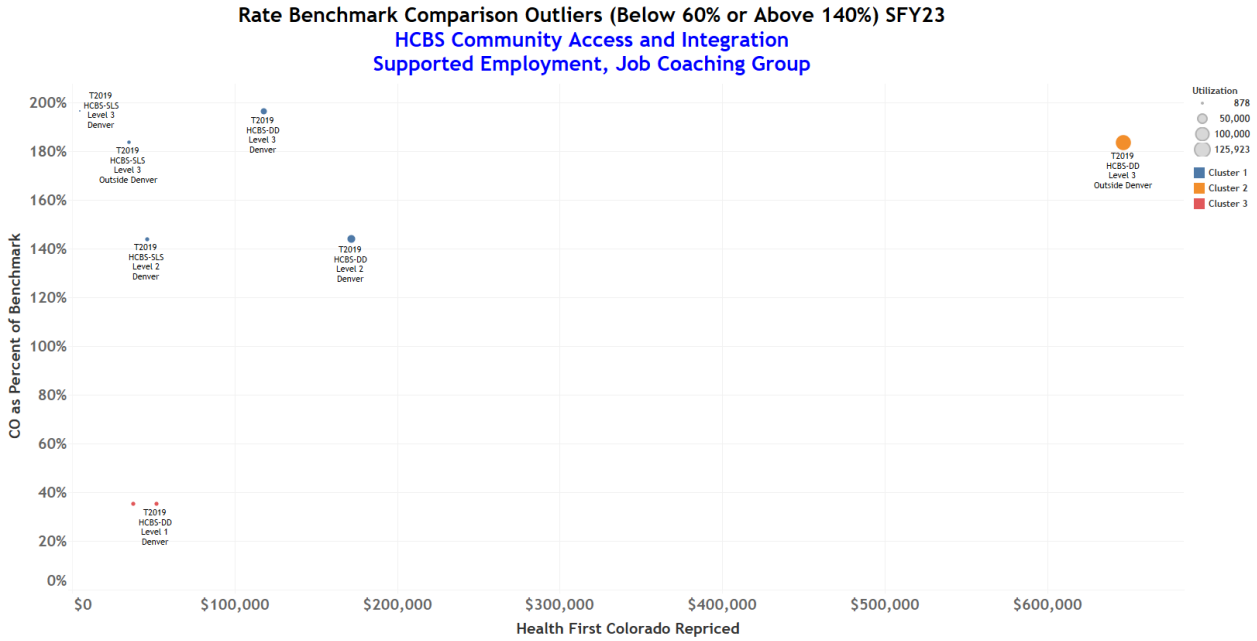


Figure 14. Bubble chart indicating the outliers under 60% and over 140% found for HCBS community access and integration (T2019).

The bubble chart below shows one data point for procedure code H2023, associated with the waiver program HCBS-SLS and the modifier "U8, HQ" within Denver County. This data point lacks utilization data and falls below 60% of the benchmark when the rate-only comparison was conducted.

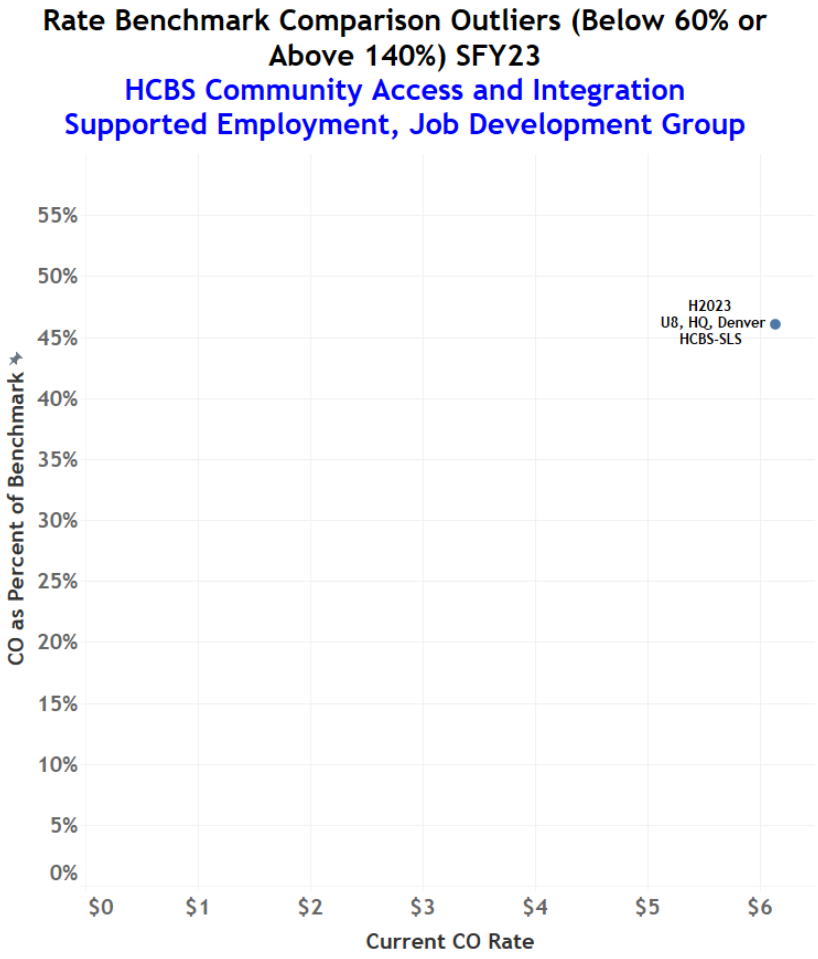


Figure 15. Bubble Chart indicating the outliers under 60% found for HCBS community access and integration (H2023)

Recommendations

Both the MPRRAC and HCPF have made one recommendation for all HCBS categories, therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Consumer Directed Attendant Support Services (CDASS)

Service Description

This is a service-delivery option that allows HCBS waiver participants to direct and manage the attendants who provide their personal care, homemaker, and health maintenance services, rather than working through an agency. Through CDASS, participants are empowered to hire, train and manage attendants of their choice to best fit their unique needs or they may delegate these responsibilities to an authorized representative.

- Enhanced Homemaker
- Health Maintenance
- Homemaker
- Personal Care

The HCBS consumer directed attendant support services (HCBS CDASS) grouping has 2 procedure codes.

- Code T2025 has 30 county and waiver program combinations. The average rate of these combinations was compared to the rates from the following 5 states: Illinois, Montana, Ohio, South Dakota, and Utah.
- Code T2040 has 10 county and waiver program combinations. The average rate of these combinations was compared to the rates from the following 3 states: Montana, Utah, and Wisconsin.

HCBS Consumer Directed Attendant Support Services Statistics	
Total Members Utilizing Services in SFY 2022-23	4,042
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	-1.03%
Total Active Providers SFY 2022-23	2
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	0.00%

Table 32. HCBS CDASS total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

HCPF has conducted a rate only comparison analysis for HCBS CDASS because of its unique attribution/delivery model.

CDASS Delivery Model

CDASS is a delivery model that allows member flexibility in using certain HCBS waiver services: personal care, homemaker, and health maintenance services. Through CDASS members have the employer authority to:

- Hire attendants;
- Determine attendant wages;
- Determine attendant schedules; and
- Coordinate the amount of personal care, homemaker, and health maintenance services to best meet their individual needs.

In some situations, members on qualifying HCBS waivers may instead access personal care, homemaker, and health maintenance services through an agency. The payment methodology and available data for these services differs based on whether services are accessed through an agency or through CDASS.

CDASS Example

To provide an example, consider a member whose service plan indicates that the member needs 10 units of homemaker services and 20 units of personal care services. Through an agency, the member would receive care based on their submitted prior authorization request (PAR), provided by an attendant arranged by the agency. The agency would then submit a claim for reimbursement for services provided. If the member's needs were to change and, for example, the member now needed 5 units of homemaker and 25 units of personal care services, the member would work with their case manager to submit an updated PAR. The member would not be able to use additional units or modify services received until the PAR has been revised.

However, if this same member was authorized for the same 10 units of homemaker services and 20 units of personal care service through CDASS, a set dollar amount would be allocated to the member. The member then arranges for attendant services and has the ability to modify the amount of homemaker and personal care services they receive. The table below shows how reimbursement is then allocated to the member and how it can be changed to meet the member's individual needs.

HCBS CDASS Delivery Model Example

Service	Authorized Units	Utilized Units	Unit Rate	Payment to Attendant
Homemaker	10	5	$4.65/15 min	5 X $4.65=$23.25
Personal Care	20	25	$4.65/15 min	25 X $4.65=$116.25
Total	**30**	**30**		**$139.50 (Total Allocation to Member)**

Table 33. HCBS CDASS delivery model example.

If the member's needs were to change and, for example, the member now needs 25 units of personal care services, the member would have the flexibility to schedule attendants for additional hours of personal care and reduce their use of homemaker services to 5 units. CDASS members can substitute services to respond to changing needs as long as their allocation amount is not exceeded. Since members have this flexibility and are not required to follow the service type authorized to determine their allocation for services, HCPF lacks access to utilized units by services. Instead, HCPF has access to the overall total payment to all attendants. Additionally, if the member chooses to pay the attendant a higher wage than the unit rate used in the allocation formula, the member would receive fewer hours of service, and HCPF would not have access to this information.

CDASS CO Repriced Calculation

Utilization data is typically employed for fiscal impact assessments. However, the distinct attribution model in CDASS makes it unsuitable for fiscal impact analysis. To substitute utilization data with expenditure data in calculating the CO repriced value, the following steps were undertaken:

1. Services were consolidated into two procedure codes (T2025 and T2040) according to their nature, and average rates for July 2022 and July 2023 were calculated.

2. The rate increase percentage from SFY 2021-22 to SFY 2022-23 was applied to reprice the expenditure amount from SFY 2022-23 to estimate the CO repriced value.

CDASS Benchmark Ratio Calculation

Without utilization and service-specific provider payment information, HCPF conducted a rate only comparison for these services.

After the services were consolidated into two procedure codes, one code (T2025) was compared to the rates from other five states (Illinois, Montana, Ohio, Utah, and South Dakota), and the other one code (T2040) was compared to the rates from other three states (Montana, Utah, and Wisconsin). Individual rate ratios for HCBS CDASS were 73.37% - 82.15%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

HCPF prepared a panel size and penetration rate analysis. The panel size appeared to be skewed due to the nature of the service, only 3 billing providers were reported in the data and that was later reduced to two. This wasn't indicative of the actual rendering providers for the service. The penetration rates for HCBS CDASS are in line with the previous review.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Day Program

Service Description

Services that provide daily support and activities for HCBS waiver participants, allowing them to participate in community life while receiving necessary assistance. Programs often focus on enhancing independence, social integration, and skill development that take place in a non-residential setting separate from the member's private residence or residential arrangement.

- Adult Day Basic (1/2 Day, 15 min)
- Adult Day Services (15 min, Day)
- Adult Day Specialized
- Day Habilitation, Specialized Habilitation
- Day Habilitation, Supported Community Connections
- Day Habilitation, Supported Community Connections, Individual, All Support Levels Tier 3
- Prevocational Services
- Telehealth Day Habilitation
- Day Treatment

The rates for HCBS day program services were compared to rates in Connecticut, Illinois, Montana, Ohio, and Utah.

HCBS Day Program Statistics	
Total Adjusted Expenditures SFY 2022-23	$52,934,069
Total Members Utilizing Services in SFY 2022-23	12,594
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	5.35%
Total Active Providers SFY 2022-23	472
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	2.61%

Table 34. HCBS day program total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS day program are estimated at 70.10% the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Day Program Rate Benchmark Comparison		
Colorado Repriced	**6 States Repriced**	**Rate Benchmark Comparison**
$52,934,069	$75,513,260	70.10%

Table 35. Comparison of Colorado Medicaid HCBS day program service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be $22,579,191 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 79 procedure codes/modifiers analyzed in this service grouping, 35 (44.31%) of them were compared to the rates of 5 other states, 4 (5.06%) of them used case-by-case negotiated rate instead of a fixed rate, and 40 (50.63%) of them did not have benchmark state data. Individual rate ratios for HCBS day program services were between 17.87% - 201.94%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 60), the number of utilizers per provider for the HCBS day program category has been steadily increasing over the last three state fiscal years, following a sharp decline in early SFY 2020-21. This initial decrease was caused by a significant drop in both utilizers and providers in July and August 2020. However, both utilization and the number of providers have been steadily rising since then. The statewide provider participation rate (Appendix B, Figure 62) remained relatively stable from 2020 to 2022, consistently ranging between 97% and 99%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization. The table below ranks the procedure codes with the highest utilization for HCBS day program services. These codes represent 96.41% of the utilization for this service category and is made up of three procedure codes that have unique modifiers for

each specific waivers (HCBS - CHCBS, HCBS - EBD, and HCBS - SLS) and the geography (Denver County, Outside of Denver county).

	HCBS Day Program Top 10 Procedure Codes by Utilization				
Rank	**Code + Modifier[14]**	**Service Description**	**Benchmark Ratio**	**Utilization[15]**	**% of Total Utilization**
1	T2021U3TGHQ	Day Habilitation, Specialized Habilitation, Level 5	63.1%	1,551,148	20.76%
2	T2021U322HQ	Day Habilitation, Specialized Habilitation, Level 2	124.2%	1,204,223	16.12%
3	T2021U3TF22HQ	Day Habilitation, Specialized Habilitation, Level 4	81.7%	1,118,197	14.96%
4	T2021U3TFHQ	Day Habilitation, Specialized Habilitation, Level 3	111.6%	997,363	13.35%
5	T2021U822HQ	Day Habilitation, Specialized Habilitation, Level 2	124.3%	732,117	9.80%
6	S5105U1	Adult Day Basic (1/2 Day)	78.9%	485,859	6.50%
7	T2021U8HQ	Day Habilitation, Specialized Habilitation, Level 1	17.9%	406,705	5.44%

[14] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[15] Utilization refers to the total number of service units utilized for each specific procedure code.

8	T2021U3HQ	Day Habilitation, Specialized Habilitation, Level 1	17.9%	366,734	4.91%
9	T2021U8TFHQ	Day Habilitation, Specialized Habilitation, Level 3	112.3%	191,053	2.56%
10	T2021U8TGHQ	Day Habilitation, Specialized Habilitation, Level 5	64.6%	150,412	2.01%

Table 36. HCBS day program top 10 procedure codes by utilization.

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below indicates that there are three data points for procedure code S5100, associated with the waiver programs HCBS-SLS, HCBS-DD, and HCBS-BI, exceeding 140% of the benchmark.

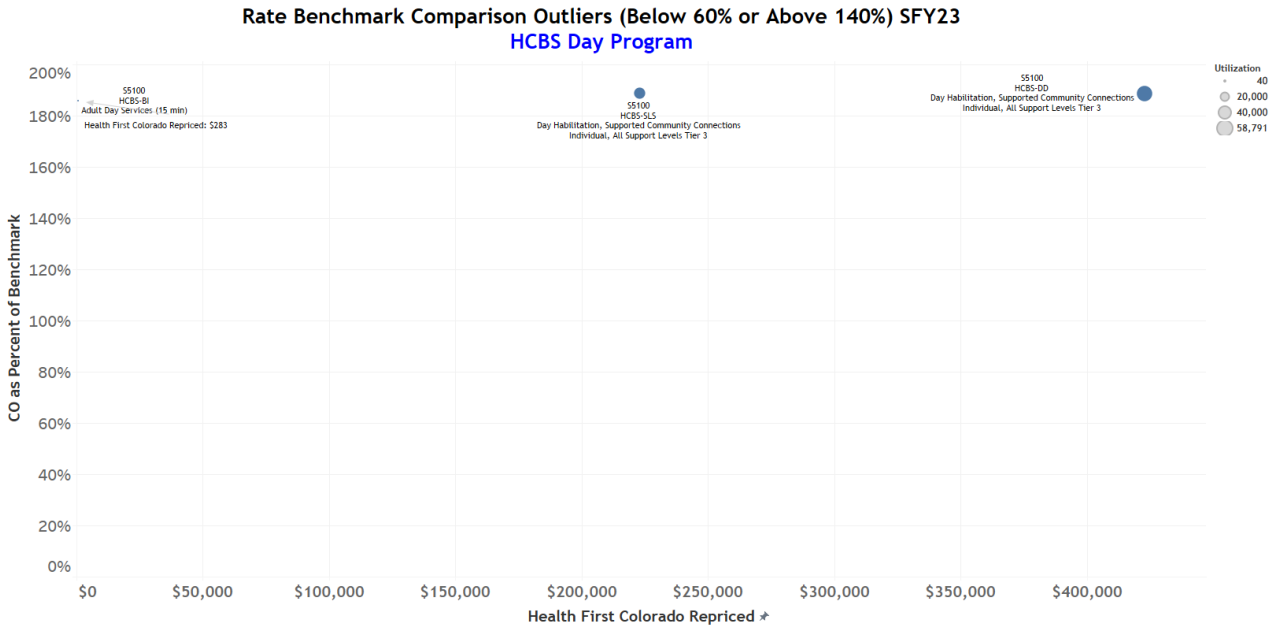


Figure 16. Bubble chart indicating the outliers over 140% found for HCBS day program (S5100).

The bubble chart below indicates that there is one data point for procedure code S5102, associated with the waiver program HCBS-BI, exceeding 140% of the benchmark.

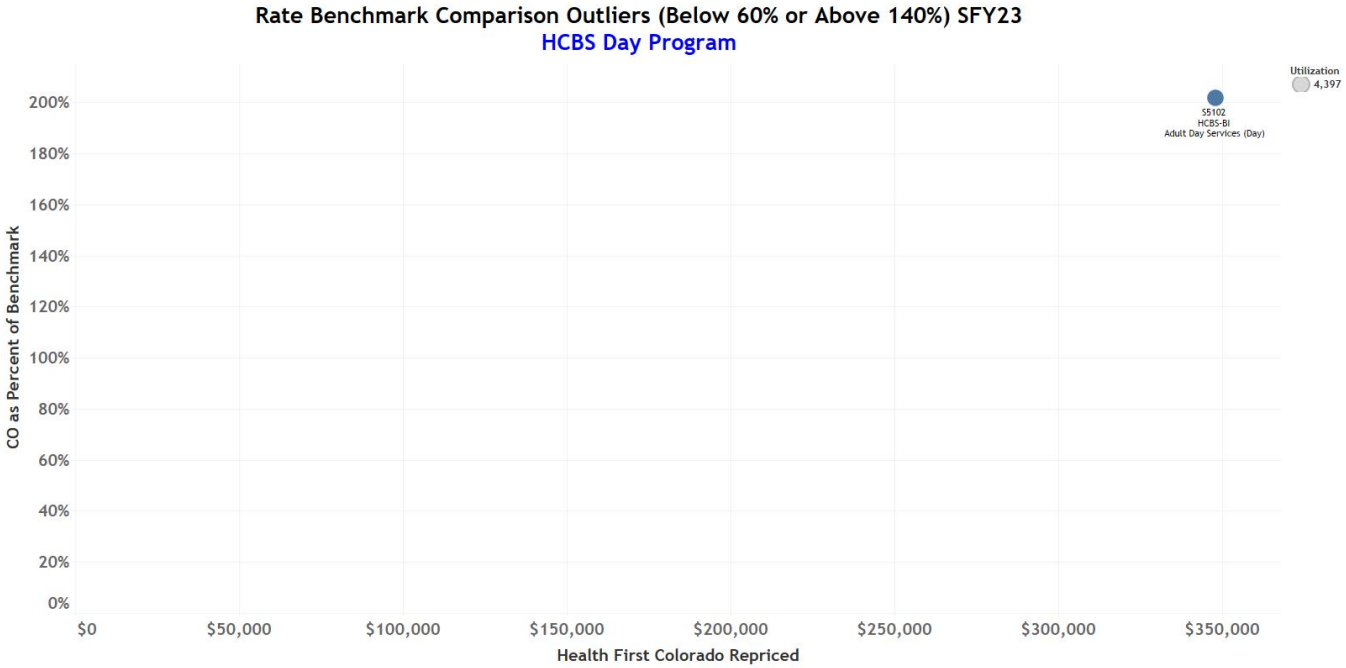


Figure 17. Bubble chart indicating the outliers over 140% found for HCBS day program (S5102).

The bubble chart below shows three data points for procedure code T2021, associated with the waiver programs HCBS-SLS and HCBS-DD. Two data points, linked to both waiver programs with service description “Day Habilitation, Specialized Habilitation, Level 1” outside Denver County, are under 60% of the benchmark. Another data point, linked to the waiver program HCBS-SLS with service description “Day Habilitation, Specialized Habilitation, Level 3” in Denver County, exceeds 140% of the benchmark.

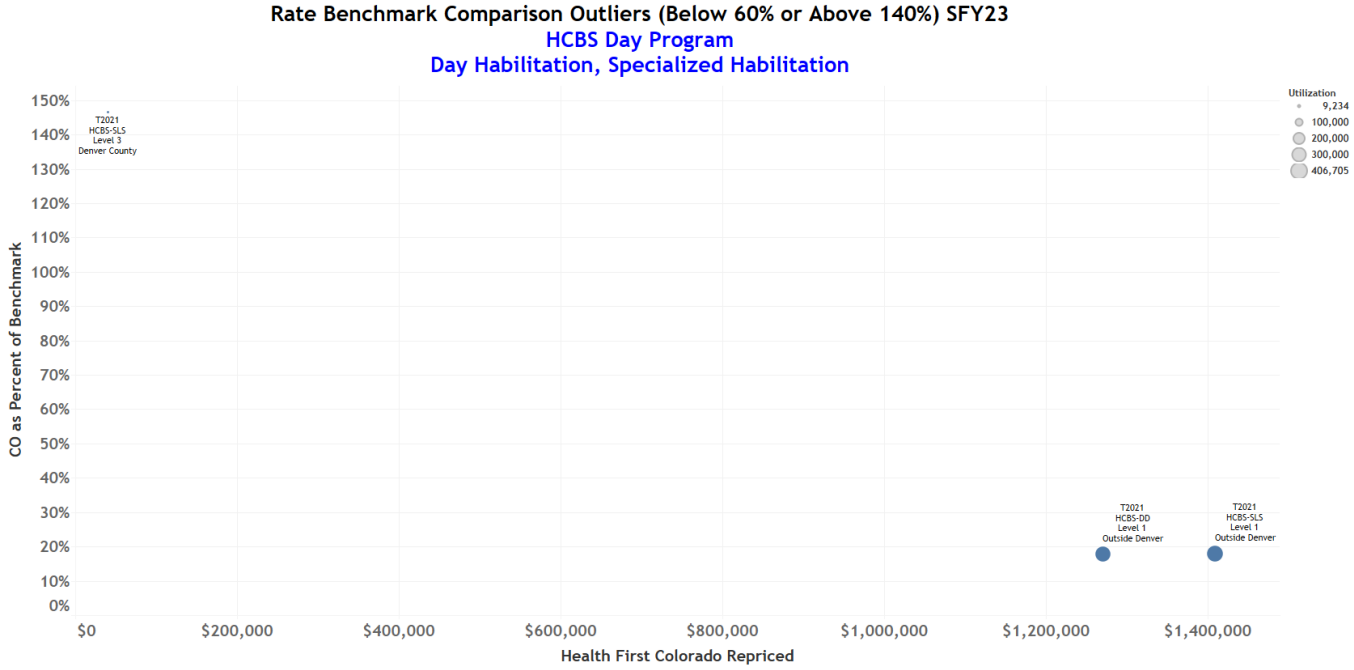


Figure 18. Bubble Charts indicating the outliers under 60% and over 140% found for HCBS day program (T2021).

Recommendations

The MPRRAC has made one recommendation for all HCBS categories, therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Professional Services

Service Description

These services refer to a range of support services provided to waiver participants that cover various aspects of care, therapy, and assistance to enhance the individual's well-being and independence.

- Acupuncture
- Art and Play Therapy
- Art and Play Therapy Group
- Chiropractic
- Dental Services (Basic/Major)
- Hippotherapy (Group/Individual)
- Massage Therapy
- Mental Health Counseling (Family/Group/Individual)
- Movement Therapy (Bachelors/Masters)
- Music Therapy
- Music Therapy Group
- Palliative/Supportive Care Skilled, Care Coordination
- Palliative/Supportive Care Skilled, Pain and Symptom Management
- Substance Abuse Counseling (Family/Group/Individual)
- Therapeutic Services, Bereavement Counseling
- Therapeutic Services, Therapeutic Life Limiting Illness Support (Family/Group/Individual)
- Vision

The rates for HCBS professional services were compared to rates in Connecticut, Illinois, and Oklahoma.

HCBS Professional Services Statistics	
Total Adjusted Expenditures SFY 2022-23	$2,236,939
Total Members Utilizing Services in SFY 2022-23	4,233
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	3.90%
Total Active Providers SFY 2022-23	96
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-7.69%

Table 37. HCBS professional services total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS professional services are estimated at 109.70% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Professional Services Rate Benchmark Comparison		
Colorado Repriced	**5 States Repriced**	**Rate Benchmark Comparison**
$2,236,939	2,039,141	109.70%

Table 38. Comparison of Colorado Medicaid HCBS professional service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($197,798) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 44 procedure code/modifier/county/waiver program combinations analyzed in this service group, 8 (18.18%) of them were compared to the rates of 3 other states, 4 (9.09%) of them used case-by-case negotiated rate instead of a fixed rate, and 32 (72.73%) of them didn't have benchmark state data. Individual rate ratios for HCBS professional services were between 92.57% - 109.78%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 64), the number of utilizers per provider for the HCBS professional services category has been stable over the last two state fiscal years after a noticeable drop from SFY 2020-21 in urban areas. This occurred because the number of providers for this service increased while utilizers remained relatively stable. In both rural and frontier areas, the panel size remained stable for the last three state fiscal years. The statewide provider participation rate (Appendix B, Figure 66) remained relatively stable from 2020 to 2022, consistently ranging between 99% and 100%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each category. The table below ranks the procedure codes with the highest utilization for HCBS professional services. These codes represent 100.00% of the utilization for this service category and is made up of three procedure codes that have unique modifiers for each specific waivers (HCBS - CHCBS, HCBS - DD, HCBS - EBD, and HCBS - SLS) and the geography (Denver County, Outside of Denver county). These procedure codes represent 100% of the codes with a benchmark ratio.

	HCBS Professional Services Top Procedure Codes by Utilization				
Rank	**Code + Modifier[16]**	**Service Description**	**Benchmark Ratio**	**Utilization[17]**	**% of Total Utilization**
1	97124U7	Massage Therapy	109.8%	64,149	56.18%
2	97124U8	Massage Therapy	109.8%	33,147	29.03%
3	97124U1SC	Massage Therapy	109.8%	14,277	12.50%
4	97124U9	Massage Therapy	109.8%	1,300	1.14%
5	97124UD	Massage Therapy	109.8%	964	0.85%
6	H0004U6	Mental Health Counseling, Individual	92.6%	342	0.30%

[16] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[17] Utilization refers to the total number of service units utilized for each specific procedure code.

Table 39. HCBS professional services top procedure codes ranked by utilization.

Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Residential Services

Service Description

These services aim to promote independence, community integration, and individualized care in a home-like environment. It provides support and assistance with managing household tasks and activities in residential settings, such as in the homes of members, the homes of small groups of individuals living together, or the homes of host families.

- Alternative Care Facility
- Foster Home
- Group Home
- Mental Health Transitional Living Homes Level 1
- Residential Child Care Facility (RCCF)
- Residential Habilitation, Group Residential Services and Supports
- Residential Habilitation, Individual Residential Services and Supports
- Residential Habilitation, Individual Residential Services and Supports, Host Home
- Supported Living Program
- Transitional Living Program

The rates for HCBS residential services were compared to rates in Connecticut, Montana, North Dakota, Ohio, South Dakota and Utah.

HCBS Residential Services Statistics	
Total Adjusted Expenditures SFY 2022-23	$201,324,716
Total Members Utilizing Services in SFY 2022-23	12,634
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	2.23%
Total Active Providers SFY 2022-23	698
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-2.51%

Table 40. HCBS residential services total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS residential services are estimated at 114.93% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Residential Services Rate Benchmark Comparison		
Colorado Repriced	**5 States Repriced**	**Rate Benchmark Comparison**
$201,324,716	$175,175,141	114.93%

Table 41. Comparison of Colorado Medicaid HCBS residential services payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($26,149,575) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 99 procedure codes/modifiers analyzed in this service group, 33 (33.33%) of them were compared to the rates of 6 other states, 15 (15.15%) of them used case-by-case negotiated rate instead of a fixed rate, and 51 (51.52%) of them did not have benchmark state data. Individual rate ratios for HCBS residential services were between 59.16% - 369.45%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 68), the number of utilizers per provider for the HCBS residential services category has been steadily increasing over the last three state fiscal years, following a slight initial decrease in early SFY 2020-21. However, the urban region experienced a slight decline towards the end of SFY 2022-23 due to a small reduction in the number of utilizers. The statewide provider participation rate (Appendix B, Figure 70) remained at 100% from 2020 to 2022. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure codes with the highest utilization for HCBS residential services. These codes represent 99.86% of the codes with a benchmark utilization for this service category and is made up of two

procedure codes that have unique modifiers for each specific waivers (HCBS - CMHS, HCBS - DD and HCBS - EBD) and the geography (Denver County, Outside of Denver county).

	HCBS Residential Services Top 10 Procedure Codes by Utilization				
Rank	**Code + Modifier[18]**	**Service Description**	**Benchmark Ratio**	**Utilization[19]**	**% of Total Utilization**
1	T2031U1	Alternative Care Facility	99.9%	630,803	35.79%
2	T2031UA	Alternative Care Facility	100.3%	460,347	26.12%
3	T2016U322	Residential Habilitation, Individual Residential Services and Supports Level 2	165.4%	295,549	16.77%
4	T2016U322 TT	Residential Habilitation, Individual Residential Services and Supports, Host Home Level 2	152.1%	234,272	13.29%
5	T2016U322 HQ	Residential Habilitation, Group Residential Services and Supports Level 2	101.3%	36,088	2.05%
6	T2016U3TF 22HQ	Residential Habilitation, Group Residential Services and Supports Level 4	101.9%	25,241	1.43%

[18] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[19] Utilization refers to the total number of service units utilized for each specific procedure code.

7	T2016U3TGHQ	Residential Habilitation, Group Residential Services and Supports Level 5	99.8%	22,888	1.30%
8	T2016U3TFHQ	Residential Habilitation, Group Residential Services and Supports Level 3	103.9%	21,985	1.25%
9	T2016U3TG22HQ	Residential Habilitation, Group Residential Services and Supports Level 6	110.3%	16,770	0.95%
10	T2016U3HQ	Residential Habilitation, Group Residential Services and Supports Level 1	105.1%	16,083	0.91%

Table 42. HCBS residential services top 10 procedure codes ranked by utilization

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below shows seven data points for procedure code T2016 associated with the waiver programs HCBS-CHRP, HCBS-BI and HCBS-DD. One data point, linked to the waiver program HCBS-CHRP outside Denver county, falls below 60% of the benchmark. Four data points are linked to the waiver program HCBS-DD. Two of them have modifier "U3, 22" with service description "Residential Habilitation, Individual Residential Services and Supports Level 2" both in and outside Denver county, exceeding 140% of the benchmark. The other two have modifier "U3, 22, TT" and service description "Residential Habilitation, Individual Residential Services and Supports, Host Home Level 2" both in and outside Denver county, exceeding 140% of the benchmark. The remaining two data points, linked to the waiver program HCBS-BI with modifier "U6" and service description "Transitional Living Program" both in and outside Denver County, exceed 140% of the benchmark.

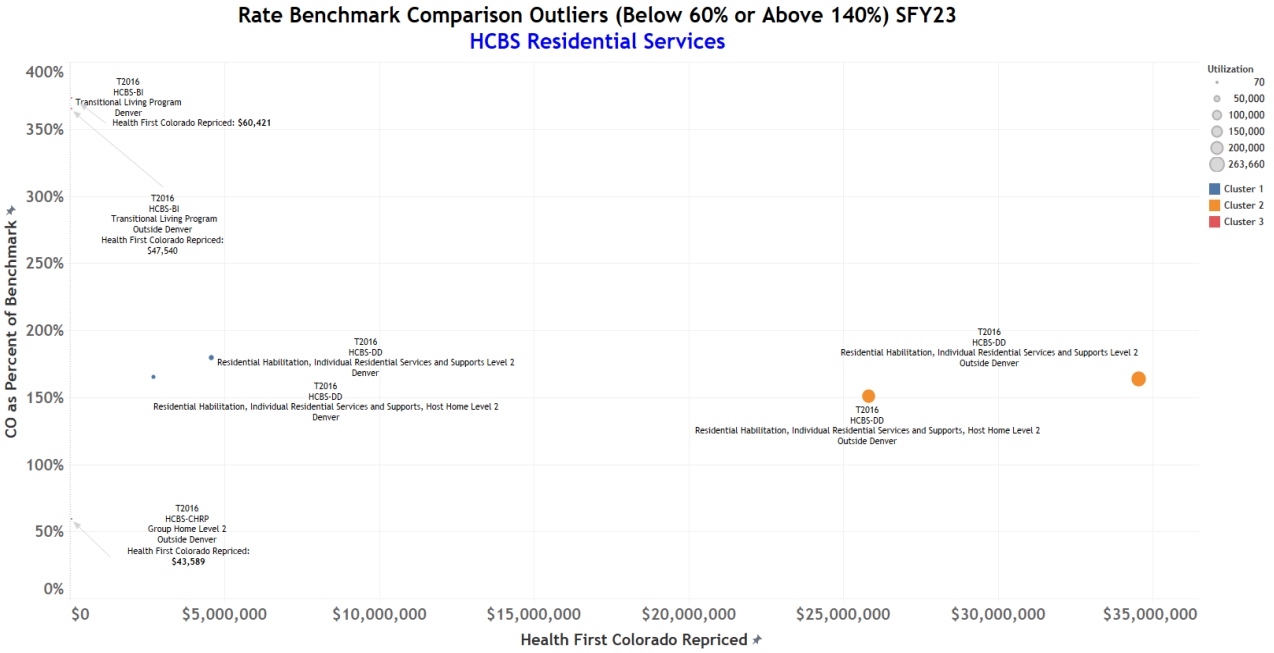


Figure 19. Bubble chart indicating the outliers under 60% and over 140% found for HCBS residential services (T2016).

The bubble chart below shows two data points for procedure code T2016 that lack utilization data and fall below 60% of the benchmark when rate only comparison was conducted. These two data points are associated with the waiver program HCBS-CHRP with modifier "U9" both in and outside Denver County.

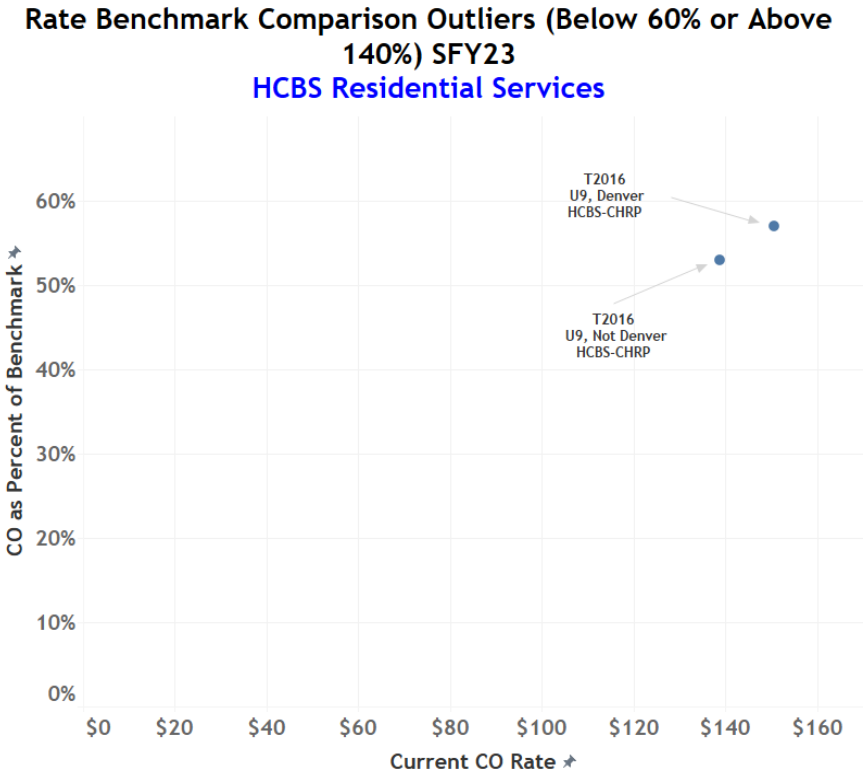


Figure 20. Bubble chart indicating the outliers under 60% found for HCBS residential services (T2016).

Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Respite Services

Service Description

These types of services typically involve temporary relief for individuals who have a disability or chronic health condition and for their primary caregivers, allowing them to rest, attend to personal needs, or take care of other responsibilities while ensuring their loved ones receive appropriate care.

- Respite Care, Alternative Care Facility
- Respite Care, Group
- Respite Care, In Home/Individual/Unskilled Respite (15 Minute Unit)/ Individual- In Family Home (15 Minute Unit)
- Respite Care, Individual - In Residential Settings
- Respite Care, Individual Day - In Residential Settings
- Respite Care, Individual Day/Unskilled (4 Hours or More)/ Individual- In Family Home
- Respite Care, Nursing Facility
- Respite Services, Camp (Group Overnight)
- Respite Services, CNA (4 hours or less)
- Respite Services, CNA (4 hours or more)
- Respite Services, Skilled RN/LPN (4 hours or less)
- Respite Services, Skilled RN/LPN (4 hours or more)
- Youth Day Services (Group/Individual)

The rates for HCBS respite services were compared to rates in Connecticut, Ohio, and Utah.

HCBS Respite Services Statistics	
Total Adjusted Expenditures SFY 2022-23	$20,785,533
Total Members Utilizing Services in SFY 2022-23	3,053
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	5.57%
Total Active Providers SFY 2022-23	259
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-9.12%

Table 43. HCBS respite services total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS respite services are estimated at 131.75% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Respite Services Rate Benchmark Comparison		
Colorado Repriced	**5 States Repriced**	**Rate Benchmark Comparison**
$20,785,533	$15,776,441	131.75%

Table 44. Comparison of Colorado Medicaid HCBS respite service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($5,009,092) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 75 procedure codes/modifiers analyzed in this service grouping, 49 (65.33%) of them were compared to the rates of 3 other states, and 26 (34.67%) of them did not have benchmark state data. Individual rate ratios for HCBS respite services were between 35.21% - 176.32%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 72), the number of utilizers per provider for the HCBS respite services category has shown a noticeable increase in urban areas over the last three state fiscal years. This trend occurred because the number of utilizers increased while the number of providers remained relatively steady. In contrast, both frontier and rural areas experienced some fluctuations in this metric during SFY 2020-21 and SFY 2021-22 due to the small number of utilizers and providers, but it remained relatively stable in SFY 2022-23. The statewide provider participation rate (Appendix B, Figure 74) remained relatively stable from 2020 to 2022, consistently ranging between 98% and 100%. These trends indicate that member access to care is stable.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure codes with the highest utilization for HCBS respite services. These codes represent 99.99% of the utilization for this service category and is made up of three procedure codes that have unique modifiers for each specific waivers (HCBS - CES, HCBS - EBD and HCBS - SLS) and the geography (Denver County, Outside of Denver county).

	HCBS Respite Services Top 10 Procedure Codes by Utilization				
Rank	**Code + Modifier[20]**	**Service Description**	**Benchmark Ratio**	**Utilization[21]**	**% of Total Utilization**
1	S5150U7	Respite Care, In Home/Individual/Unskilled Respite (15 Minute Unit)/ Individual- In Family Home (15 Minute Unit)	147.7%	1,808,279	64.92%
2	S5150U8	Respite Care, In Home/Individual/Unskilled Respite (15 Minute Unit)/ Individual- In Family Home (15 Minute Unit)	148.2%	941,946	33.82%
3	S5150U1	Respite Care, In Home/Individual/Unskilled Respite (15 Minute Unit)/ Individual- In Family Home (15 Minute Unit)	176.3%	18,953	0.68%
4	S5150U9HA	Respite Care, In Home/Individual/Unskilled Respite (15 Minute Unit)/ Individual- In Family Home (15 Minute Unit)	126.0%	4,699	0.17%

[20] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[21] Utilization refers to the total number of service units utilized for each specific procedure code.

5	S5151U8	Respite Care, Individual Day/Unskilled (4 Hours or More)/ Individual- In Family Home	81.3%	4,620	0.17%
6	S5151U7	Respite Care, Individual Day/Unskilled (4 Hours or More)/ Individual- In Family Home	81.3%	2,975	0.11%
7	H0045U1	Respite Care, Nursing Facility	72.9%	1,929	0.07%
8	S5151U1	Respite Care, Alternative Care Facility	35.2%	484	0.02%
9	S5151U9HA	Respite Care, Individual Day/Unskilled (4 Hours or More)/ Individual- In Family Home	82.4%	481	0.02%
10	S5151UA	Respite Care, Alternative Care Facility	35.2%	365	0.01%

Table 45. Top 10 HCBS respite services procedure codes ranked by utilization

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below shows seven data points for procedure code S5150 that exceed 140% of benchmark rate. Two of them are associated with the waiver program HCBS-EBD with modifier “U1” for both in and outside Denver county. Two of them are associated with the waiver program HCBS-CES with modifier “U7” for both in and outside Denver county. Two of them are associated with the waiver program HCBS-SLS with modifier “U8” for both in and outside Denver county. The remaining one is associated with the waiver program HCBS-BI with modifier “U6” for outside Denver county.

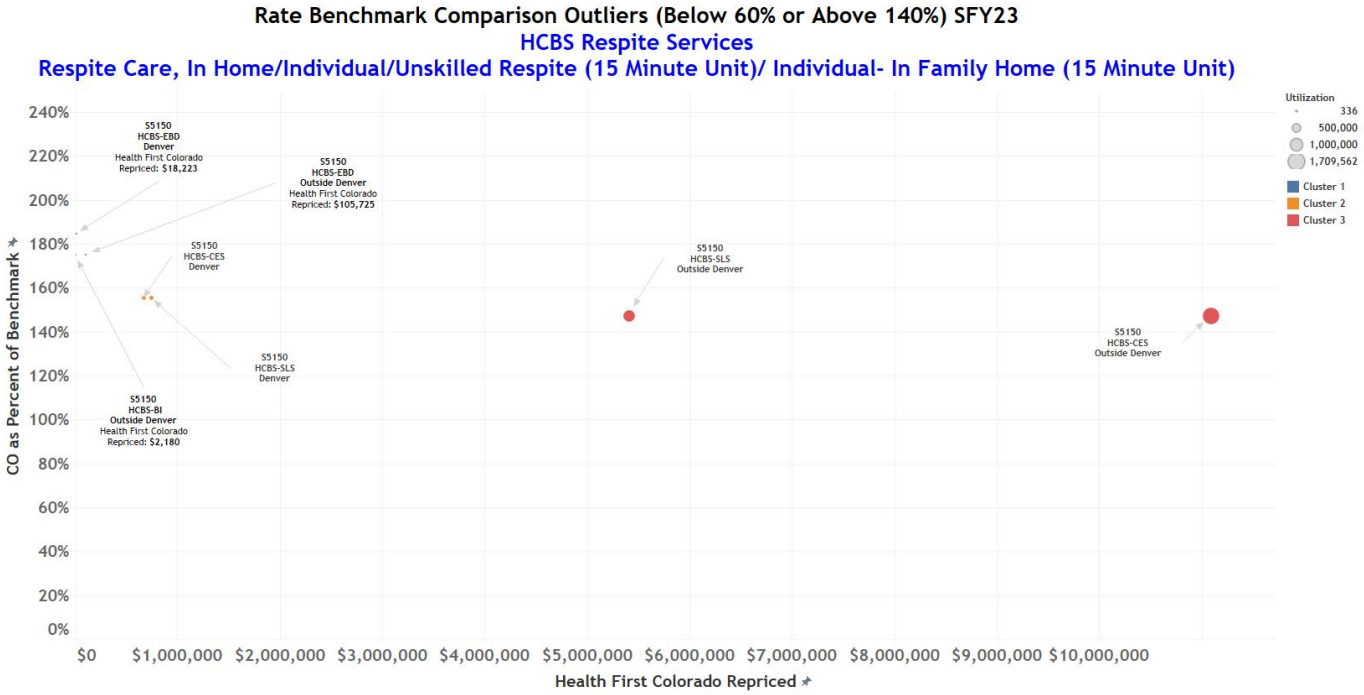


Figure 21. Bubble chart indicating the outliers over 140% for HCBS respite services (S5150).

The bubble chart below shows three data points for procedure code S5151 outside Denver county that fall below 60% of benchmark rate. Two data points have service description as “Respite Care, Alternative Care Facility”. One of the two has the modifier “U1” and is associated with the waiver program HCBS-EBD. The other one has the modifier “UA” and is associated with the waiver program HCBS-CMHS. The remaining data point is associated with the waiver program HCBS-CLLI with the modifier “UD” and service description “Respite Care, Individual Day/Unskilled (4 Hours or More)/ Individual- In Family Home”.

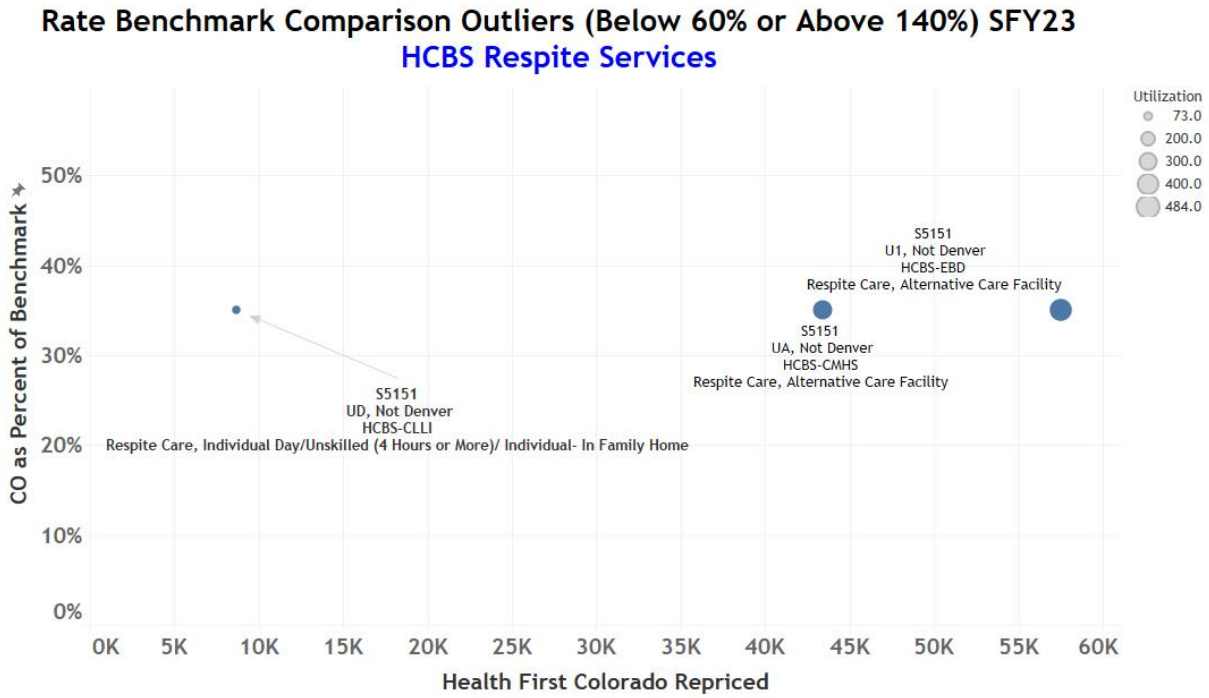


Figure 22. Bubble chart indicating the outliers under 60% for HCBS respite services (S5151).

The bubble chart below shows five data points for procedure code S5151 that lack utilization data and fall below 60% of the benchmark when rate only comparison was conducted. One data point is associated with the waiver program HCBS-EBD and modifier "U1" in Denver county. One data point is associated with the waiver program HCBS-CMHS and modifier "UA" in Denver county. One data point is associated with the waiver program HCBS-CLLI and modifier “UD” in Denver county. The remaining two data points are linked to the waiver program HCBS-CIH and "U1, SC" modifier for both in and outside Denver county.

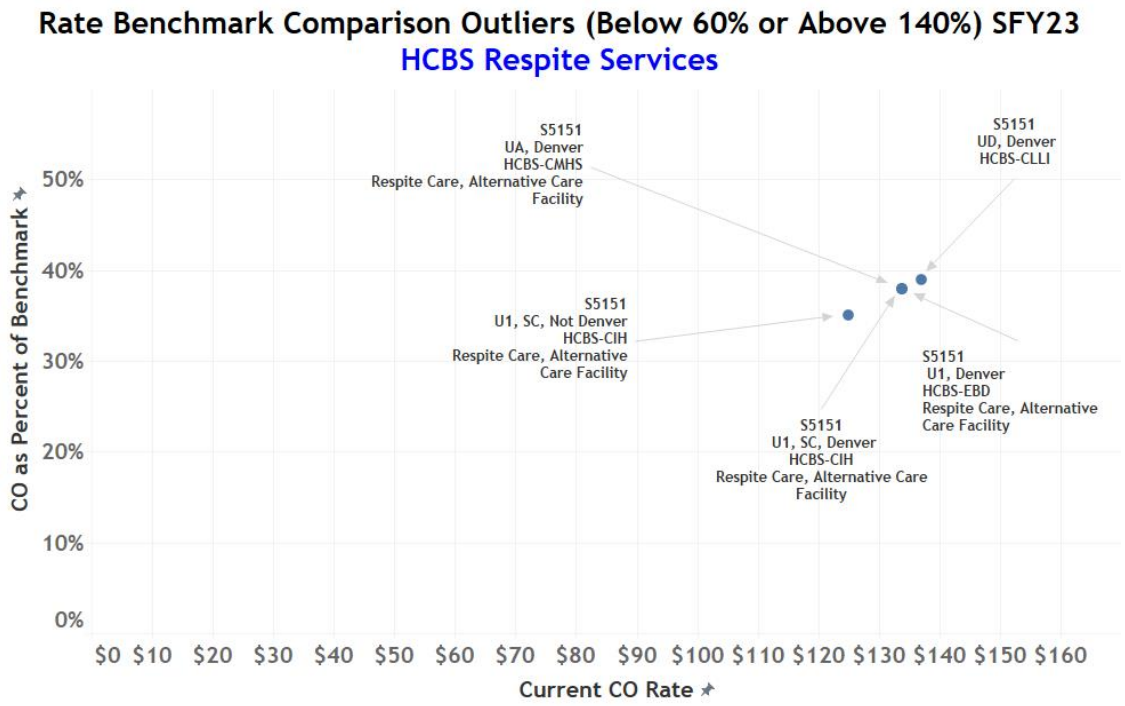


Figure 23. Bubble chart indicating the outliers under 60% for HCBS respite services (S5151).

The bubble chart below shows five data points for procedure code S5150 that lack utilization data and exceed 140% of the benchmark when rate only comparison was conducted. One data point is associated with the waiver program HCBS-BI and modifier "U6" in Denver county. Two data points are associated with the waiver program HCBS-CIH and modifier "U1, SC" both in and outside Denver county. The remaining two data points are linked to the waiver program HCBS-CLLI and modifier "UD" both in and outside Denver county.

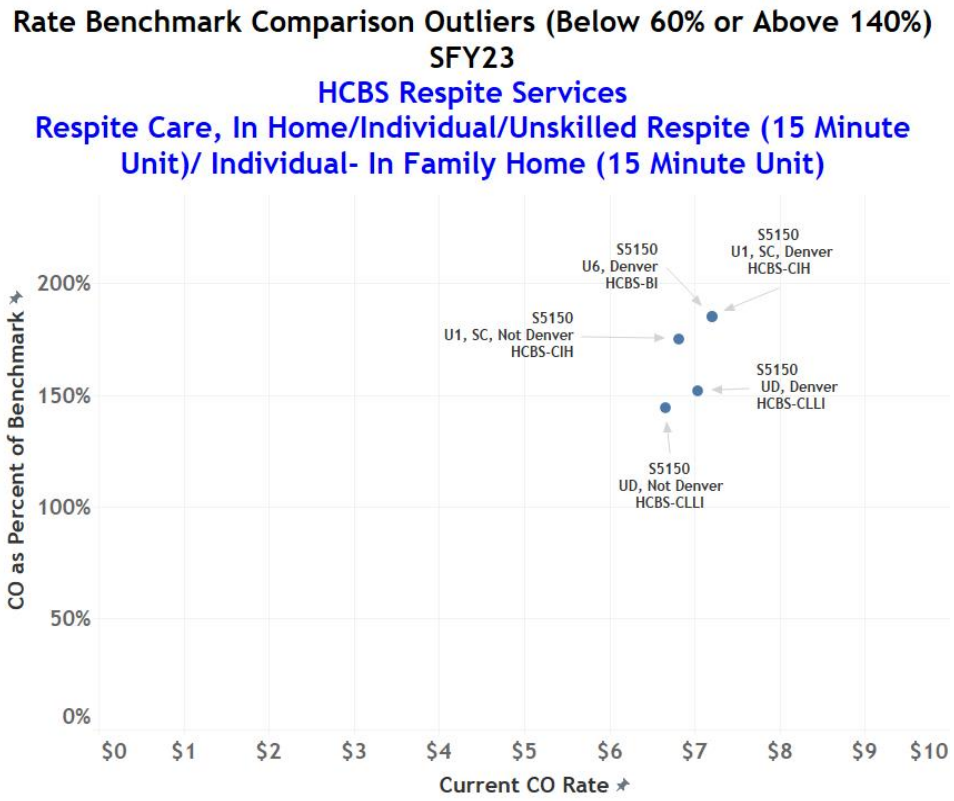


Figure 24. Bubble chart indicating the outliers over 140% found for HCBS respite services (S5150).

The bubble chart below shows six data points for procedure code T1005 that lack utilization data and exceed 140% of the benchmark when a rate only comparison was conducted. Two data points are associated with the waiver program HCBS-CLLI and modifier "UD" both in and outside Denver county. Two data points are associated with the waiver program HCBS-CES and modifier "U7" both in and outside Denver county. The remaining two data points are linked to the waiver program HCBS-CHRP and modifier "U9" both in and outside Denver county.

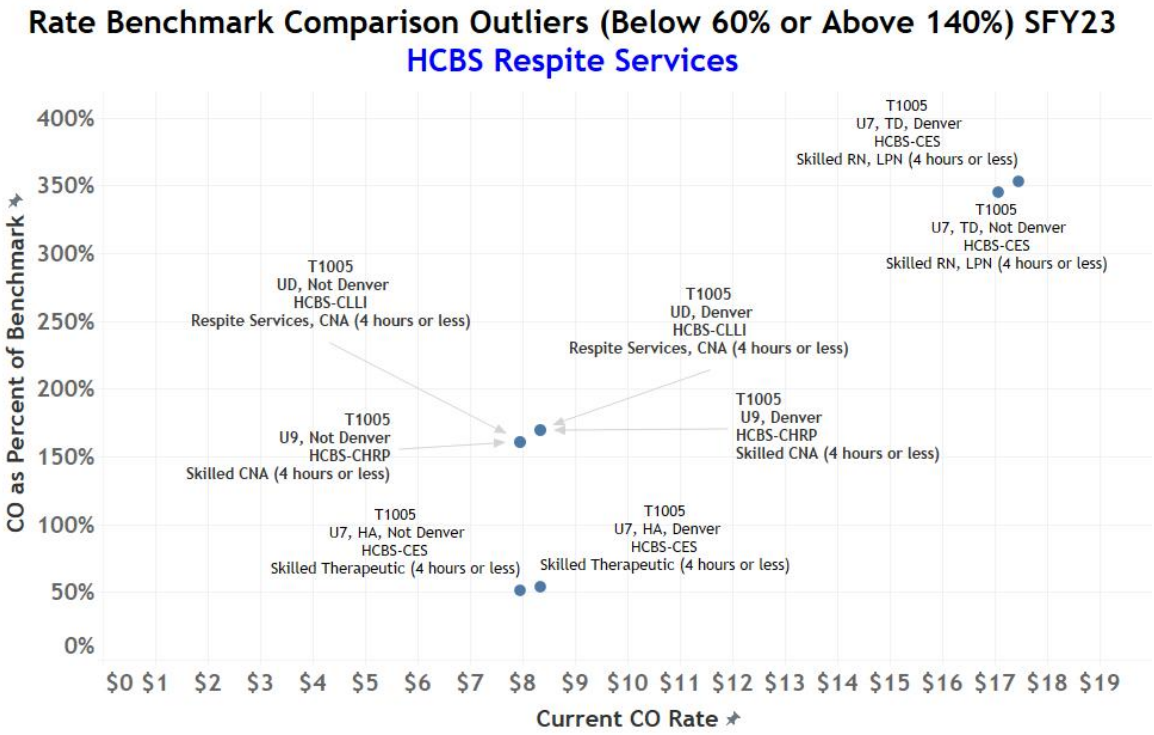


Figure 25. Bubble chart indicating the outliers over 140% found for HCBS respite services (T1005).

Recommendations

The MPRRAC has made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Technology, Adaptations and Equipment

Service Description

These types of services typically refer to support provided to participants through the use of assistive technology, adaptations, and specialized equipment.

- Adapted Therapeutic Recreational Equipment and Fees
- Assistive Devices
- Assistive Technology
- Home Modification
- Medication Reminder, Install/Purchase/Monitoring
- Personal Emergency Response System
- Personal Emergency Response System, (Install/Purchase/Monitoring/Remote Supports Install/Purchase)
- Remote Supports Technology (Remote Supports Install/Purchase)
- Specialized Medical Equipment and Supplies (Disposable Supplies/Equipment)
- Vehicle Modifications

HCBS Technology, Adaptations and Equipment Statistics	
Total Members Utilizing Services in SFY 2022-23	20,334
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	-2.04%
Total Active Providers SFY 2022-23	116
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-19.44%

Table 46. HCBS technology, adaptations and equipment total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

A rate comparison analysis was not possible to complete for HCBS technology, adaptations and equipment due to the highly specific nature and rates for these services. There are 41 procedure code/modifier/county/waiver program combinations in this service group, 21 (51.22%) of them used case-by-case negotiated rate instead of a fixed rate, and 20 (48.78%) of them did not have benchmark state data.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 76), the number of utilizers per provider for the HCBS technology, adaptations, and equipment category has noticeably increased in urban areas over the last three state fiscal years. This trend is

due to a big decrease in the number of providers during this period. In contrast, this metric has remained relatively stable in both frontier and rural areas because the numbers of both utilizers and providers have decreased.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Recommendations

Both the MPRRAC and HCPF have made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home & Community Based Services - Transition Services

Service Description

Transition services are designed to assist waiver participants in transitioning from institutional or residential settings to community-based living arrangements. These services aim to support a smooth and successful transition by addressing various aspects of the individual's needs.

- Community Transition Services, Coordinator
- Community Transition Services, Setup Expenses
- Home Delivered Meals
- Home Delivered Meals Post-Hospital Discharge
- Life Skills Training
- Peer Mentorship

The rates for HCBS transition services were compared to rates in Connecticut, Illinois, Montana, North Dakota, Ohio, Oklahoma, Utah and Wisconsin.

HCBS Transition Services Statistics	
Total Adjusted Expenditures SFY 2022-23	$4,440,773
Total Members Utilizing Services in SFY 2022-23	668
SFY 2022-23 Over SFY 2021-22 Change in Members Utilizing Services	36.33%
Total Active Providers SFY 2022-23	27
SFY 2022-23 Over SFY 2021-22 Change in Active Providers	-6.90%

Table 47. HCBS transition services total expenditure and utilization data (SFY 2022-23).

Rate Comparison Analysis

On average, Colorado Medicaid payments for HCBS transition services are estimated at 106.25% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

HCBS Transition Services Rate Benchmark Comparison		
Colorado Repriced	**8 States Repriced**	**Rate Benchmark Comparison**
$4,440,773	$4,179,656	106.25%

Table 48. Comparison of Colorado Medicaid HCBS transition service payments to those of other payers, expressed as a percentage (SFY 2022-23).

The estimated fiscal impact after living cost adjustment to Colorado Medicaid would be ($261,117) total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2022-2023. Of the 40 procedure code/modifier/county/waiver program combinations

analyzed in this service group, 22 (55%) of them were compared to the rates of 8 other states, and 18 (45%) of them did not have benchmark state data. Individual rate ratios for HCBS transition services were 24.62% - 144.98%.

The states chosen for the rate comparison analysis had similar geographical settings with extreme rural areas along with urban and more populated areas. In addition, these states have comparable benefit packages or cover comparable services, have public fee schedules and use a fee-for-service model similar to Colorado.

Access to Care Analysis

See Appendix B for the full access to care analysis.

As seen in the panel size visual (Appendix B, Figure 78), the number of utilizers per provider for the HCBS transition services category had substantial fluctuations over the last three state fiscal years; moreover, the metric in rural areas is higher than that in urban areas. This is due to the low number of providers. However, only a few Medicaid members per year qualify for transition services. The statewide provider participation rate (Appendix B, Figure 80) remained at 100% in both 2020 and 2021, but experienced a 9% drop to 91% in 2022.

Stakeholder Feedback

See Appendix E for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes ranked by utilization for each service category. The table below ranks the procedure codes with the highest utilization for HCBS transition services. These codes represent 99.89% of the codes with a benchmark with utilization for this service category and is made up of three procedure codes that have unique modifiers for each specific waivers (HCBS - BI, HCBS - CHMS, HCBS - CIH, HCBS - EBD and HCBS - SLS).

	HCBS Transition Services Top 10 Procedure Codes by Utilization				
Rank	Code + Modifier[22]	Service Description	Benchmark Ratio	Utilization[23]	% of Total Utilization
1	H2014U1	Life Skills Training	103.0%	262,936	71.19%
2	S5170U1	Home Delivered Meals	136.3%	65,973	17.86%
3	H2014UA	Life Skills Training	103.0%	19,905	5.39%
4	S5170UA	Home Delivered Meals	136.3%	10,543	2.85%
5	H2015U1	Peer Mentorship	24.6%	3,678	1.00%
6	H2014U1SC	Life Skills Training	103.0%	2,576	0.70%
7	H2014U8	Life Skills Training	103.0%	908	0.25%
8	H2015UA	Peer Mentorship	24.6%	900	0.24%
9	S5170U6	Home Delivered Meals	136.3%	764	0.21%
10	S5170U8	Home Delivered Meals	136.3%	748	0.20%

Table 49. HCBS transition services top 10 procedure codes ranked by utilization.

[22] Please refer to Appendix A3 for a complete list of procedure/revenue code descriptions.
[23] Utilization refers to the total number of service units utilized for each specific procedure code.

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as rates in CO that are under 60% or above 140% of the benchmark.

The bubble chart below shows two data points for procedure code H2015 that fall under 60% of benchmark. One data point is associated with the waiver programs HCBS-EBD with modifier “U1”. The other data point is linked to the waiver program HCBS-CMHS with modifier “UA”.

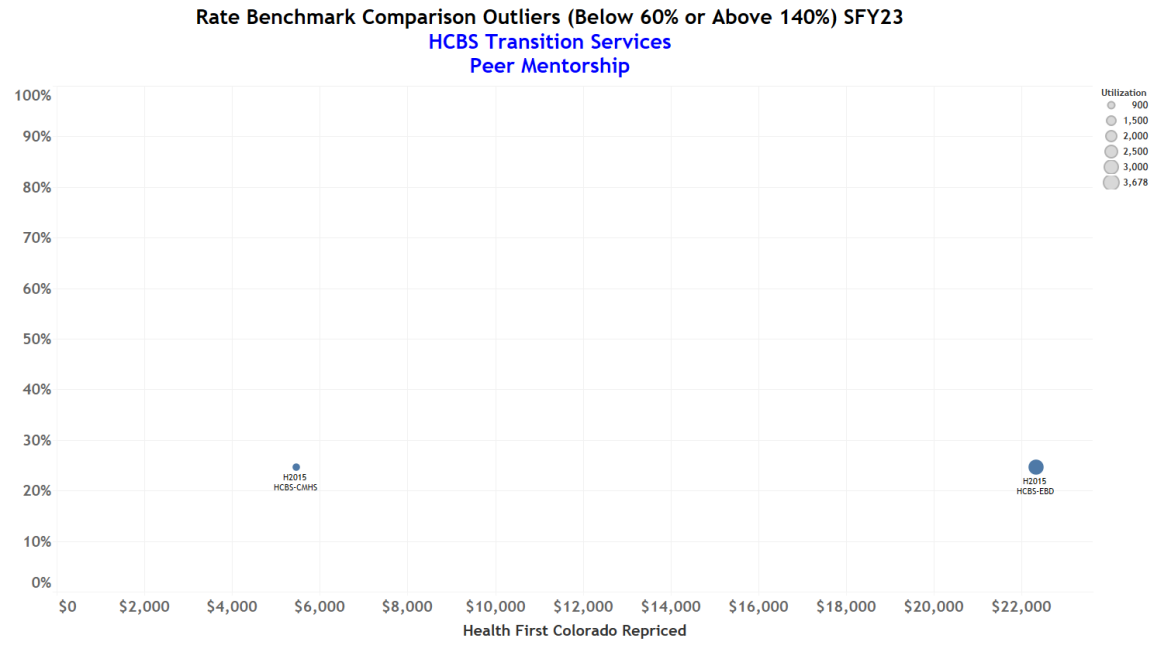


Figure 26. Bubble chart indicating the outliers under 60% found for HCBS transition services (H2015).

The bubble chart below shows one data point for procedure code S5170 that exceeds 140% of the benchmark. This data point is linked to the waiver program HCBS-EBD with modifier “U1, TF”.

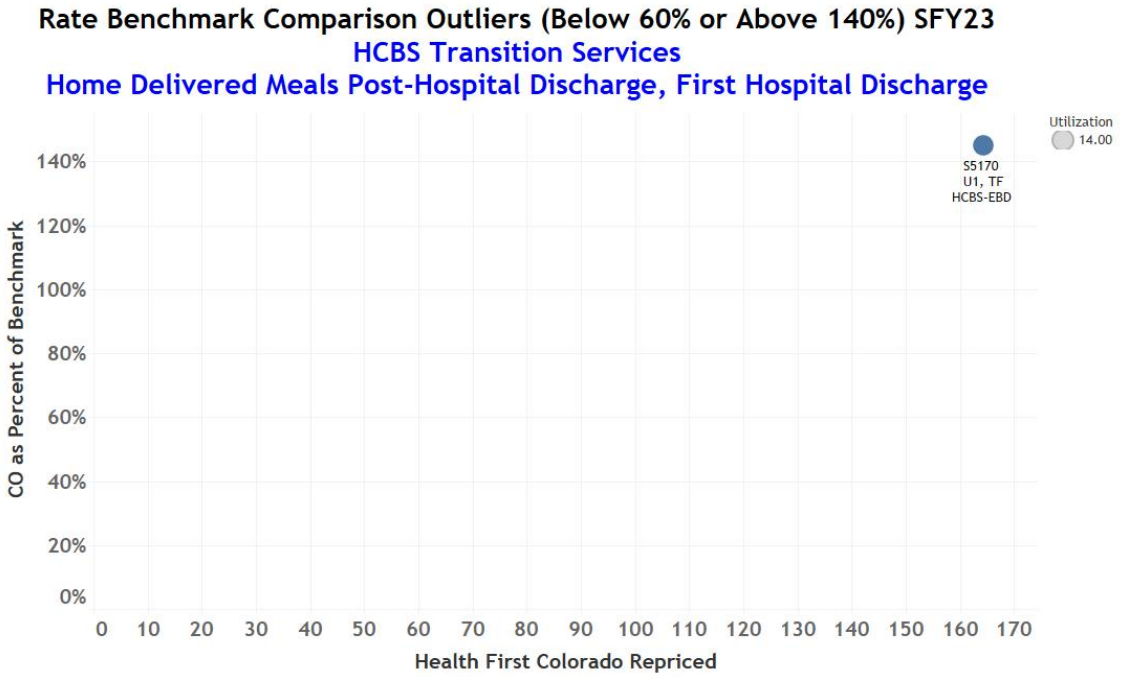


Figure 27. Bubble chart indicating the outliers over 140% found for HCBS transition services (S5170).

The bubble chart below shows five data points for procedure code S5170 that lack utilization data and exceed 140% of the benchmark when rate only comparison was conducted. One data point is associated with the waiver programs HCBS-CIH with modifier “U1, SC, TF”. One data point is associated with the waiver programs HCBS-DD with modifier “U3, TF”. One data point is associated with the waiver programs HCBS-BI with modifier “U6, TF”. One data point is associated with the waiver programs HCBS-SLS with modifier “U8, TF”. The remaining data point is associated with the waiver programs HCBS-CMHS with modifier “UA, TF”.

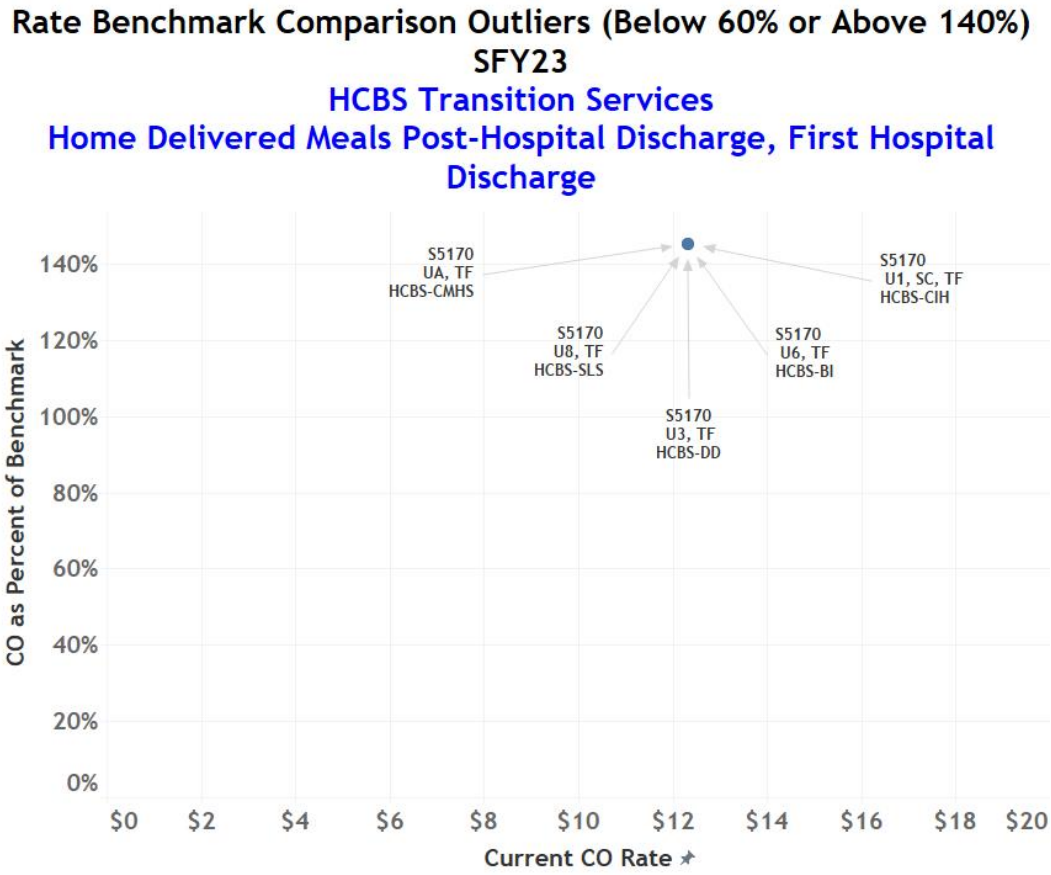


Figure 28. Bubble chart indicating the outliers over 140% found for HCBS transition services (S5170).

The bubble chart below shows four data points for procedure code H2015 that lack utilization data and fall under 60% of the benchmark when rate only comparison was conducted. One data point is associated with the waiver programs HCBS-CIH with modifier “U1, SC”. One data point is associated with the waiver programs HCBS-DD with modifier “U3”. One data point is associated with the waiver programs HCBS-BI with modifier “U6”. The remaining data point is associated with the waiver program HCBS-SLS with modifier “U8”.

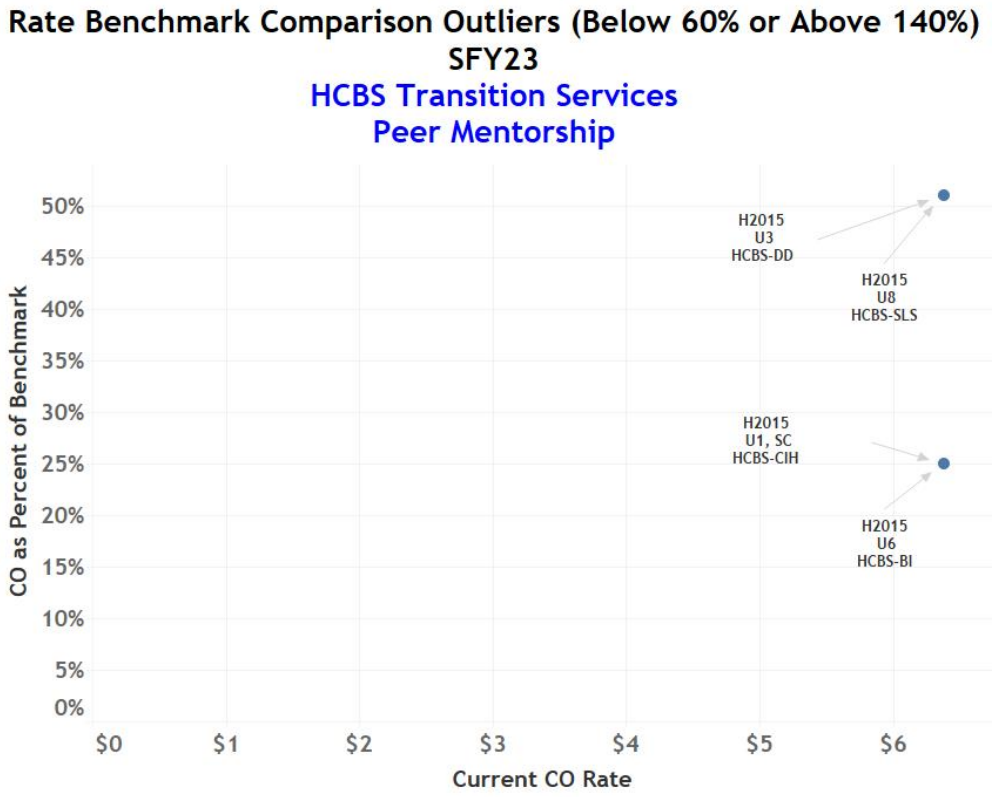


Figure 29. Bubble chart indicating the outliers under 60% found for HCBS transition services (H2015).

Recommendations

Both the MPRRAC and HCPF have made one recommendation for all HCBS categories; therefore, HCPF has created one section at the end of all HCBS sections to present this information. Please refer to pages 104 - 106 of the report.

Home and Community Based Services - MPRRAC and HCPF Recommendations

The MPRRAC has made the same recommendations for each individual HCBS service category.

MPRRAC Recommendations - All HCBS Categories

- The MPRRAC recommends increasing the rates of all codes under 100% of the benchmark ratio to 100% of the benchmark, and no change to the rates of codes with a benchmark ratio above 100%.
- The MPRRAC recommends that for codes without a benchmark ratio but that have proxy codes (codes that fall under the same procedure code but differ in service specifics), the benchmark ratio of the proxy codes should be used as their benchmark ratio. The rate should be increased to 100% of the proxy code benchmark ratio if the proxy code benchmark ratio is under 100% of the benchmark.
- The MPRRAC recommends increasing the rates for codes with neither a benchmark nor proxy codes by 3%.
- The MPRRAC recommends standardizing uneven rates for the same service across different programs by adopting the highest rate in addition to the above change.
- The MPRRAC recommends aligning the Denver rate and the non-Denver rate by selecting the higher of the two, after uneven rates adjustment.

The MPRRAC recommendation fiscal impacts broken down by individual categories are shown below.

MPRRAC Recommendation Fiscal Impact Summary By Service Category			
Service Category	**Benchmark Ratio**	**Fiscal Impact (TF)**	**Fiscal Impact (GF)**
HCBS ADL Assistance and Delivery Models	64.81%	$326,174,297	$163,087,149[24]
HCBS Behavioral Services	124.09%	$1,252,163	$626,082
HCBS Community Access and Integration	156.37%	$5,235,386	$2,617,693

[24] The HCBS ADL assistance and delivery models service category accounts for 82.6% of total utilization and 61.9% of the total CO Repriced amount among all HCBS service categories for codes with benchmark ratios.

HCBS Consumer Directed Attendant Support Services (CDASS)	73.37%-82.15%	$53,747,838	$26,873,919[25]
HCBS Day Program	70.10%	$68,831,683	$34,415,842
HCBS Professional Services	109.70%	$233,747	$116,874
HCBS Residential Services	114.93%	$56,079,846	$28,039,923
HCBS Respite Services	131.75%	$2,590,812	$1,295,406
HCBS Technology, Adaptations and Equipment	N/A	$66,999	$33,500
HCBS Transition Services	106.25%	$100,331	$50,166
Total	**76.45%**	**$514,313,102**	**$257,156,554**

Table 50. HCBS - MPRRAC recommendation fiscal impacts broken down by category.

Furthermore, HCPF has made one recommendation for the overall HCBS service category.

HCPF Recommendations - All HCBS Categories

- HCPF recognizes the importance of these services, as demonstrated by the State's investment of $839,131,448 in total funds over the past five years for HCBS, which includes $419,565,724 from the General Fund. However, due to wider budgetary challenges, HCPF recommends prioritizing the following two initiatives:
    - HCPF recommends implementing a rate adjustment for Community First Choice (CFC) codes, which involves increasing the rates for select services in some waiver programs and decreasing them for others to ensure that total costs remain balanced, without disproportionately impacting the overall budget or expenditure.
    - Due to the federal Maintenance of Expenditures (MOE) requirements, HCPF recommends that select services which are not CFC codes but subject to the CFC MOE are not impacted by any across-the-board rate reductions.

[25] The fiscal impact was calculated by multiplying the CO Repriced values derived from the "CDASS CO Repriced Calculation" section by (100% - benchmark ratio).

- The anticipated fiscal impact of HCPF's recommendation is $279,844 total funds, including $139,922 General Fund.

Policy Justification

Community First Choice expands access to home and community based services by moving selected 1915(c) waiver services into the State Plan. HCPF received legislative approval in 2023 to implement CFC through Senate Bill 23-289. The Centers for Medicare and Medicaid Services provides an additional 6% federal match on all CFC services, which is expected to save the state money. Under CFC, rates cannot fluctuate based on a member's disability or waiver enrollment, like it can within 1915(c) waivers. Therefore, before CFC can be implemented, rates must be standardized across services moving into CFC. This standardization process will lead to both increases and decreases in various waiver rates. In addition, CMS has imposed a Maintenance of Expenditures requirement on CFC, which requires the state to maintain or exceed the pre-CFC level of expenditures for the first year after CFC is implemented. This MOE is for all services moving into CFC and select services not moving into CFC. Due to these federal requirements, HCPF recommends that standardization of CFC rates be prioritized and that services subject to the CFC Maintenance of Expenditures are not impacted by any across-the-board rate reductions.

Appendices

Appendix A – Cycle 1 Year 1 Methodologies and Data

Provides explanations of methodologies and data used in this report.

Appendix A1 - Excluded Codes

Contains all of the codes that were excluded from the rate comparison analysis and the reason for their exclusion.

Appendix A2 - Base Data Summary

Contains the base data used for the rate comparison analysis. The base data includes the record counts, utilization numbers, and paid amounts as well as exclusions for each service category.

Appendix A3- Benchmark Ratios

Contains all of the codes under review, their benchmark ratios, and comparison details.

Appendix B - Access to Care Metrics

Includes visuals and an explanation of results of a service's applicable access to care measures, which include: panel size, provider participation, penetration rate, special provider, price per service, and telemedicine accessibility.

Appendix C - Rate Change Track Document for 2024 Review

Contains a detailed overview of all the codes for the services under review. Where applicable, this includes the original Colorado Medicaid rates used for repricing (July 2023 or January 2024 fee schedule), proposed rates based on MPRRAC's recommendations, proposed rates based on HCPF's recommendations, and JBC approved rates (to be added when available in spring 2025).

Appendix D - PDN Cross-work of Benchmark Rates

Provides detailed clarification on the process of correlating Colorado's revenue codes with HCPCS codes in benchmark states, and how the benchmark ratio was calculated for each revenue code for PDN services.

Appendix E - Stakeholder Feedback

Contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings.

Appendix F - Glossary and County Reference Map

Provides explanations for common terms used throughout the 2024 Medicaid Provider Rate Review Analysis Report, as well as a reference map of counties in Colorado by classification.