COLORADO
Department of Health Care Policy & Financing

Appendix A – Cycle 1 Year 2 Methodologies and Data

Executive Summary

The Colorado Department of Health Care Policy and Financing (HCPF) contracted with the actuarial firm **CBIZ Optumas (Optumas)** and worked collaboratively in comparing Colorado Medicaid provider rates to Medicare (a comparable benchmark). Many of the services reviewed for Cycle 1 Year 2 (C1Y2) did not have a comparable Medicare benchmark and other states' rates were instead used as the benchmark.

When other states' rates were used, the goal was to provide context for Colorado's fee schedule, and the best way to do that is a fairly random cross-sectional sample of states to compare against. The fact is any given state's fee schedule is independent of the demographics and economy of that state. It may be surprising, but even low-tax, low-benefits states sometimes have high fee schedules, or vice versa.

The states were chosen on several factors: they have comparable benefit packages or covered services, because their fee schedules are public, and/or Optumas had specific expertise about that state that could be leveraged. No comparison state is ever included or excluded based on the price points of its fee schedule.

Once states and rates were identified for each service, an appropriate adjustment was made to account for cost-of-living differences. Data from the Missouri Economic Research and Information Center's website was used to ensure that rates compared across state lines were appropriate.

The following services were reviewed as the 2024 Medicaid Provider Rate Review Analysis Report:

- Emergency Medical Transportation (EMT)
- Non-Emergent Medical Transportation (NEMT)
- Qualified Residential Treatment Program (QRTP)
- Psychiatric Residential Treatment Facilities (PRTF)
- Physician Services
    - Sleep Studies
    - EEG Ambulatory Monitoring Codes
- Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD)
- Home Health (HH)
- Pediatric Personal Care (PPC)

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- Private Duty Nursing (PDN)
- Home and Community Based Services (HCBS) for 10 waiver services

The work performed on Cycle 1 Year 2 services was comprised of the following analyses:

1. Data validation,
2. Rate crosswalk,
3. Utilization adjusted rate comparison

The data validation process includes:

- Volume checks over time to determine completeness and reliability of data, and
- Determination of relevant utilization base and appropriate exclusions.

The rate comparison benchmark analysis compares Colorado Medicaid's latest fee schedule estimated reimbursement with the estimated reimbursement of the overall benchmark(s). The rate comparison benchmark analysis considers Medicare rates as the comparator, though very few of the C1Y2 services had a comparable Medicare benchmark. The data used for the analysis were fee-for-service (FFS) claims incurred from July 1, 2022 through June 30, 2023 (FY23).

All else being equal, if Colorado Medicaid were to reimburse at 100.0% of the overall benchmark, expenditures for FY23 would see the estimated total funds impacts summarized in Table 1. Note that, though Home and Community Based Services (HCBS) are shown rolled up at the Waiver Service Category level, within each waiver service category, the rates were reviewed at the procedure code, modifier and county (Denver rate vs. Non-Denver rate) level.

Table 1. Colorado as a Percent of the Benchmark and Estimated FY23 Fund Impact

Service Group	*Colorado Repriced	*Benchmark Repriced	Colorado as a Percent of Benchmark	Estimated FY23 Total Fund Impact
Emergency Medical Transportation (EMT)	$63,518,591	$94,684,772	67.1%	$31,166,181
Non-Emergent Medical Transportation (NEMT)**			52.9% - 161.8%	
Qualified Residential Treatment Program (QRTP)	$4,143,580	$8,319,687	49.8%	$4,176,107
Psychiatric Residential Treatment Facility (PRTF)	$15,591,064	$15,860,034	98.3%	$268,970
Physician Services				
Sleep Studies	$3,523,786	$2,892,008	121.9%	$(631,778)
EEG Ambulatory Monitoring Codes	$2,472,339	$2,707,036	91.3%	$234,697
Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD) Codes	$87,648	$124,031	70.7%	$19,181
Home Health (HH)	$592,132,057	$835,352,952	70.9%	$243,220,895
Pediatric Personal Care (PPC)	$4,210,831	$5,005,563	84.1%	$794,732
Private Duty Nursing (PDN)	$99,824,124	$113,350,320	88.1%	$13,526,196
HCBS Service Categories				
ADL Assistance and Delivery Models	$528,069,550	$814,856,292	64.8%	$286,786,742
Behavioral Services	$3,608,285	$2,907,801	124.1%	($700,484)
Community Access and Integration	$39,618,121	$25,336,432	156.4%	($14,281,689)
Consumer Directed Attendant Support Services (CDASS)***			73.4% - 82.2%	
Day Program	$52,934,069	$75,513,260	70.1%	$22,579,191
Professional Services	$2,236,939	$2,039,141	109.7%	($197,798)
Residential Services	$201,324,716	$175,175,141	114.9%	($26,149,575)
Respite Services	$20,785,533	$15,776,441	131.8%	($5,009,092)
Technology, Adaptations and Equipment****				
Transition Services	$4,440,773	$4,179,656	106.3%	($261,117)

**** CO Repriced Amount and Benchmark Repriced Amount are adjusted for cost-of-living when compared with other states and are reduced by TPL and copayments.***

***** SFY23 data for NEMT is excluded from the utilization analysis due to on-going fraud investigation.***

****** CDASS has a quick attribution model, so it is not possible to reprice its services using benchmark rates, as such, the rate-only comparison ratio is provided.***

******* There is no appropriate benchmark rate for HCBS Technology, Adaptations and Equipment services.***

Data Validation

The Department initially provided two years (July 2021 through June 2023) of eligibility data and fee-for-service (FFS) claims data to Optumas. For the Rate Comparison analysis, the decision was made to use FY23 for the benchmark comparison. The data validation process included utilization and dollar volume summaries over time which were validated against the Department's expectations, as well as Optumas's expectations based on prior analyses to identify potential inconsistencies. In addition, a frequency analysis was performed to examine valid values appearing across all fields contained in the data. Overall, results of this process suggested that the FY23 data for each service was reliable.

Next, the data was reviewed to determine the relevant utilization after accounting for applicable exclusions. The exclusion criteria adhere to the general guidelines set forth in the Rate Review Schedule:[1]

- Claims attributed to members that are non Title TXIX Medicaid eligible, i.e., Child Health Plan Plus (CHP+) program;
- Claims attributed to members with no corresponding eligibility span; and
- *Claims associated with members enrolled in Medicaid and Medicare (dual membership).

** An exception was made for this year's review for HCBS and Home Health, per the Department's request. The Department noted that more than 50% of waiver claims were from dual eligible members, but there were no Medicare paid amounts in the claims data. As a result, the decision was made to include these dual claim lines in the analysis.*

Furthermore, for the rate comparison benchmark, the validation process included additional exclusions:

- Procedure codes or revenue codes that are on the Colorado fee schedule as "manually priced" or "not a benefit" or were not found on the schedule, which are reflected as "No CO Medicaid rate."
- Procedure codes or revenue codes that do not have a comparable benchmark, whether Medicare or other states, are reflected as "No Benchmark rate."

The detailed list of procedure codes or revenue codes that were excluded from this analysis are shown in Appendix A1.

The number of excluded procedure codes for each service group is shown in Table 2 below.

*Table 2: Counts of Excluded Codes**

Service Group	Total # of Excluded Codes	No CO Medicaid Rate	No Benchmark Rate	No Valid Utilization
Emergency Medical Transportation (EMT)	2	0	1	1
Non-Emergent Medical Transportation (NEMT)	0	0	0	0
Qualified Residential Treatment Program (QRTP)	0	0	0	0
Psychiatric Residential Treatment Facility (PRTF)	0	0	0	0
Physician Services				
Sleep Studies	9	0	3	6
EEG Ambulatory Monitoring Codes	4	0	0	4
Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD) Codes	2	0	1	1
Home Health (HH)	5	0	5	0
Pediatric Personal Care (PPC)	0	0	0	0
Private Duty Nursing (PDN)	0	0	0	0
HCBS Service Categories[2]	515	52	373	90
ADL Assistance and Delivery Models	36	0	20	16
Behavioral Services	4	0	4	0
Community Access and Integration	191	8	162	21

[1] See the Rate Review Schedule on the Department's Medicaid Provider Rate Review Advisory Committee (MPRRAC) website.

[2] For HCBS Service categories, it is the total number of combinations of codes, modifiers, county and waiver programs instead of codes alone.

Consumer Directed Attendant Support Services (CDASS)	0	0	0	0
Day Program	49	4	40	5
Professional Services	38	4	32	2
Residential Services	73	15	51	7
Respite Services	56	0	26	30
Technology, Adaptations and Equipment	41	21	20	0
Transition Services	27	0	18	9

**If a code has no CO Medicaid rate, regardless of whether it has a valid benchmark rate or utilization data, we classify it as "No CO Medicaid Rate". If a code has a CO Medicaid rate, but has no benchmark rate, regardless of whether it has valid utilization data, we classify it as "No Benchmark Rate". If a code has a CO Medicaid rate and a benchmark rate but lacks utilization data, we classify it as "No Valid Utilization".*

The number of total procedure or revenue codes, with Medicare or other states as benchmark and total excluded code count for each service group is shown in Table 3 below.

Table 3: Counts of Codes and Benchmarks Used for Each Service Group

Service Group	Total # of Codes	Medicare Benchmark Used	Other States as Benchmark	Excluded Codes
Emergency Medical Transportation (EMT)	12	9	1	2
Non-Emergent Medical Transportation (NEMT)*	19	5	14	0
Qualified Residential Treatment Program (QRTP)	1	0	1	0
Psychiatric Residential Treatment Facility (PRTF)	1	0	1	0
Physician Services				
Sleep Studies	36	27	0	9
EEG Ambulatory Monitoring Codes	23	19	0	4
Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD) Codes	7	0	5	2
Home Health (HH)	20	0	15	5
Pediatric Personal Care (PPC)	2	0	2	0
Private Duty Nursing (PDN)	5	0	5	0
HCBS Service Categories[3]	725	0	210	515
ADL Assistance and Delivery Models	72	0	36	36
Behavioral Services	11	0	7	4
Community Access and Integration	262	0	71	191
Consumer Directed Attendant Support Services (CDASS)	2	0	2	0
Day Program	79	0	30	49
Professional Services	44	0	6	38
Residential Services	99	0	26	73

[3] For HCBS Service categories, it is the total number of combinations of codes, modifiers and waiver programs instead of codes alone.

Respite Services	75	0	19	56
Technology, Adaptations and Equipment	41	0	0	41
Transition Services	40	0	13	27

* *Typically, we exclude codes lacking valid utilization data. However, NEMT presented a unique situation. Due to a significant potential fraud risk and an ongoing investigation, we were unable to use SFY23 utilization data for repricing NEMT services, so we relied on SFY22 utilization data for a proxy fiscal impact analysis. Despite this limitation, we conducted a rate-only comparison and successfully identified benchmark rates for all 19 NEMT codes. As a result, we were able to include NEMT in our analysis, rather than excluding it entirely.*

Services were priced to the Colorado Medicaid fee schedules at the procedure code or revenue code level. The summary of exclusions from the FY23 base data can be found in Appendix A2 A2(a) – A2(j).

Services were priced to the Colorado Medicaid fee schedules at the procedure code or revenue code level. FY23 claims data were selected as the base data of the repricing analysis because it yields an annualized result derived from the most recent experience. There is an inherent processing lag in claims between the time a claim is incurred and when it is billed. Claims rendered in any given month can take weeks or months to be reported in the claims system. The claims data for C1Y2 services were provided with three months of claims runout. The raw claims data reflects the vast majority of FFS experience for C1Y2 services in FY23 and the Department chose to not have Optumas perform an IBNR analysis.

After the data validations steps, the rate comparison benchmark analysis was performed.

Rate Comparison Benchmark Analysis

The first step in the rate comparison benchmark analysis was a repricing exercise using the most recent Colorado Medicaid fee schedule with rates effective January 1, 2024. There were services reviewed for C1Y2 that did not have the latest rates published effective January 1, 2024; whatever was published on the Department's website is what was used for the initial analysis. Rates effective other than January 1, 2024 are noted below.

EMT rates were reviewed by procedure code to obtain a Colorado repriced amount. No modifiers were considered when pulling rates from the Medicare fee schedule because modifiers are not considered when repricing EMT using the Colorado Medicaid fee schedule. It was then necessary to determine comparable rates using the Medicare fee schedule. To identify comparable rates, publicly available documentation on reimbursement policy was referenced, and the analysis employed fee schedules specific to Urban and Rural areas to produce a more valid comparison. For one procedure code, A0422 (life sustaining supplies), there was not a comparable Medicare rate and other states' fee schedules were used to benchmark the rate.

NEMT rates were reviewed by procedure codes. 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, we applied the rate-only comparison method for each reviewed NEMT code. The rates for 5 codes were compared to the Medicare rates. The rates for 14 codes were compared to the rates from different benchmark states.

QRTP rates were reviewed by procedure code and modifier (there is only 1). Because QRTP is not a service covered by Medicare, other states' rates were used as the comparator.

PRTF rates were reviewed by revenue code (there is only 1). Because PRTF is not a service covered by Medicare, other states' rates were used as the comparator.

Physician Services - Sleep Studies rates were reviewed by procedure code and modifiers to obtain a Colorado repriced amount. The rates for 27 code-modifier combinations were compared to Medicare rates. There was no utilization data for 6 code-modifier combinations, and a rate-only comparison was performed using Medicare rates. For 3 code-modifier combinations, there was no benchmark rate to use for comparison.

Physician Services - EEG Ambulatory Monitoring rates were reviewed by procedure code to obtain a Colorado repriced amount. The rates for all codes were compared to Medicare rates. Out of the 23 codes, 4 had no utilization data, and a rate-only comparison was performed using Medicare as the comparator.

HH rates were reviewed by revenue code, some of which were further broken down by modifier code, to obtain a Colorado repriced amount. None of the codes had comparable Medicare benchmark rates and other states' rates were used.

FFS BH SUD rates were reviewed by procedure code to obtain a Colorado repriced amount. None of the codes had comparable Medicare benchmark rates and other state's rates were used.

PPC rates were reviewed by procedure code (there is only 1), but the analysis was bifurcated by county (Denver versus all other counties). PPC is not a service covered by Medicare, so other states' rates were used as the comparator.

PDN rates were reviewed by revenue code to obtain a Colorado repriced amount. None of the codes had comparable Medicare benchmark rates and other states' rates were used.

HCBS rates were reviewed by waiver, service category, procedure code, multiple modifiers, and by counties (Denver versus all other counties). All HCBS rates were compared with other states' rates.

For all reviewed services using other states' rates for benchmark (e.g., HH, PPC, PDN or HCBS), both Colorado Medicaid rates and benchmark states' rates were adjusted based on the current Cost of Living Index, which was sourced from the Missouri Economic Research and Information Center's website, with Q2 2024 as the reference period. The adjusted Colorado Medicaid rates and the average rates from benchmark states after cost-of-living adjustment, were then applied to reprice the Colorado Medicaid utilization data. After this, the TPL and copay amounts were deducted. The benchmark ratio was calculated by dividing the repriced Colorado amount by the repriced benchmark amount.

If there were claims in the base data for which neither a Medicare benchmark nor another state's rates could be found, the utilization associated with these non-comparable claims were excluded for the remainder of the rate comparison benchmark analysis.

The final step consisted of applying the base utilization to Colorado Medicaid's latest available fee schedule as well as the matched rates from Medicare or other states' Medicaid rates. This entailed

multiplication of utilization and the corresponding rates from each source, followed by subtraction of third-party liability (TPL) and copayments, to calculate the estimated total dollars that would theoretically be reimbursed by each source.

The range of ratios derived from comparing Health First Colorado rates to those of the appropriate comparator is shown by the service group in Table 4.

Table 4: Rate Ratio Ranges

Service Group	Benchmark
Emergency Medical Transportation (EMT)	53.3% – 86.7%
Non-Emergent Medical Transportation (NEMT)	52.9% - 161.8%
Qualified Residential Treatment Program (QRTP)	49.8%
Psychiatric Residential Treatment Facility (PRTF)	98.3%
Physician Services	
Sleep Studies	28.1% - 239.2%
EEG Ambulatory Monitoring Codes	48.2% - 334.7%
Fee-for-service (FFS) Behavioral Health Substance Use Disorder (SUD) Codes	44.3% - 108.2%
Home Health (HH)	58.1% - 251.2%
Pediatric Personal Care (PPC)	82.1% - 88.7%
Private Duty Nursing (PDN)	68.6% - 95.1%
HCBS Service Categories	
ADL Assistance and Delivery Models	46.7% - 103.9%
Behavioral Services	35.3% - 295.1%
Community Access and Integration	7.5% – 394.1%
Consumer Directed Attendant Support Services (CDASS)	N/A
Day Program	17.9% - 201.9%
Professional Services	92.6% - 109.8%
Residential Services	59.2% - 369.5%
Respite Services	35.2% - 176.3%
Technology, Adaptations and Equipment	N/A
Transition Services	24.6% - 145.0%

As an example, the top figures in Table 4 can be interpreted to mean that when comparing EMT Services to the appropriate comparator rates by code, the Colorado Medicaid rates were anywhere from 53.3% to 86.7% of the benchmark rate.

Estimated expenditures were only compared for the subset of Cycle 1 Year 2 services that are common between Colorado Medicaid and Medicare or other states. In other words, if no comparable rate could be found for a specific service offered in Colorado Medicaid, then the associated utilization and costs were not shown within the comparison results.

In the service-specific payment comparison sections of the narrative that follow, more detailed information can be found on the Benchmark portions of the rate comparison.

Emergency Medical Transportation Payment Comparison

There is a matching Medicare rate for over 99.8% of the Emergency Medical Transportation utilization in FY23 and the remaining utilization was compared with an average of other states' Medicaid rates after living cost adjustment.

Table 5.1 summarizes the payment comparison and estimated fiscal impact.

Table 5.1: EMT Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	67.1%
*Colorado Repriced Amount	$63,518,591
Benchmark Repriced Amount	$94,684,772
Est. FY23 Total Fund Impact	$31,166,181

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.1 can be interpreted to mean that for Emergency Medical Transportation services under review, Colorado Medicaid pays an estimated 67.1% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $31,166,181. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "EMT").

Non-Emergent Medical Transportation Payment Comparison

As mentioned in section "Rate Comparison Benchmark Analysis", due to an on-going fraud investigation, the utilization data for NEMT in SFY23 is unusable. We applied the rate-only comparison method for each reviewed NEMT code, and the individual rate ratios for NEMT were 52.88% - 161.78%. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "EMT").

Qualified Residential Treatment Program Payment Comparison

There are no matching Medicare rates for QRTP utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.2 summarizes the payment comparison and estimated fiscal impact.

Table 5.2: QRTP Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	49.8%
*Colorado Repriced Amount	$4,143,580
Benchmark Repriced Amount	$8,319,687
Est. FY23 Total Fund Impact	$4,176,107

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.2 can be interpreted to mean that for QRTP services under review, Colorado Medicaid pays an estimated 49.8% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $4,176,107. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "QRTP").

Psychiatric Residential Treatment Facility Payment Comparison

There are no matching Medicare rates for PRTF utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.3 summarizes the payment comparison and estimated fiscal impact.

Table 5.3: PRTF Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	98.3%
*Colorado Repriced Amount	$15,591,064
Benchmark Repriced Amount	$15,860,034
Est. FY23 Total Fund Impact	$268,970

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.3 can be interpreted to mean that for PRTF services under review, Colorado Medicaid pays an estimated 98.3% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $268,971. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "PRTF").

Physician Services - Sleep Studies

There is a matching Medicare rate for 100% of the Physician Services - Sleep Studies utilization in FY23.

Table 5.4 summarizes the payment comparison and estimated fiscal impact.

Table 5.4: Physician Services - Sleep Studies Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	121.9%
*Colorado Repriced Amount	$3,523,786
Benchmark Repriced Amount	$2,892,008
Est. FY23 Total Fund Impact	$(631,778)

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.4 can be interpreted to mean that for Physician Services - Sleep Studies services under review, Colorado Medicaid pays an estimated 121.9% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $(631,778). Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "Sleep Study").

Physician Services - EEG Ambulatory Monitoring Codes

There is a matching Medicare rate for 100% of the Physician Services - EEG Ambulatory Monitoring Codes utilization in FY23.

Table 5.5 summarizes the payment comparison and estimated fiscal impact.

Table 5.5: Physician Services - EEG Ambulatory Monitoring Codes Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	91.3%
*Colorado Repriced Amount	$2,472,339
Benchmark Repriced Amount	$2,707,036
Est. FY23 Total Fund Impact	$234,697

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.5 can be interpreted to mean that for Physician Services - EEG Ambulatory Monitoring Codes services under review, Colorado Medicaid pays an estimated 91.3% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $234,697. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "EEG").

Fee-for-Service Behavioral Health (BH) Substance Use Disorder (SUD) Payment Comparison

There are no matching Medicare rates for FFS BH SUD utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.6 summarizes the payment comparison and estimated fiscal impact.

Table 5.6: FFS BH SUD Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	70.67%
*Colorado Repriced Amount	$87,648

Benchmark Repriced Amount	$124,031
Est. FY23 Total Fund Impact	$36,383

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.6 can be interpreted to mean that for FFS BH SUD services under review, Colorado Medicaid pays an estimated 70.67% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $36,383. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "FFS BH SUD").

Home Health Payment Comparison

There are no matching Medicare rates for HH utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.7 summarizes the payment comparison and estimated fiscal impact.

Table 5.7: HH Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	70.88%
*Colorado Repriced Amount	$592,132,057
Benchmark Repriced Amount	$835,352,952
Est. FY23 Total Fund Impact	$243,220,895

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is other states' Medicaid rates.*

Table 5.7 can be interpreted to mean that for Home Health services under review, Colorado Medicaid pays an estimated 70.88% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $243,220,895. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "HH").

Pediatric Personal Care Payment Comparison

There are no matching Medicare rates for PPC utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.8 summarizes the payment comparison and estimated fiscal impact.

Table 5.8: PPC Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	84.1%
*Colorado Repriced Amount	$4,210,831
Benchmark Repriced Amount	$5,005,563

Est. FY23 Total Fund Impact	$794,732

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.8 can be interpreted to mean that for PPC services under review, Colorado Medicaid pays an estimated 84.1% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $794,732. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "PPC").

Private Duty Nursing Payment Comparison

There are no matching Medicare rates for PDN utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator.

Table 5.9 summarizes the payment comparison and estimated fiscal impact.

Table 5.9: PDN Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	88.1%
*Colorado Repriced Amount	$99,824,124
Benchmark Repriced Amount	$113,350,320
Est. FY23 Total Fund Impact	$13,526,196

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.9 can be interpreted to mean that for PDN services under review, Colorado Medicaid pays an estimated 88.1% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $13,526,196. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC Main| tab (filter the service category column as "PDN").

Home and Community Based Services Payment Comparison

There are no matching Medicare rates for HCBS utilization in FY23. An average of other states' rates after living cost adjustment was used as the comparator. It should be noted that Consumer Directed Attendant Support Services (CDASS) were removed from this analysis since it is not possible to reprice the services based on fee schedules. Another caveat to this analysis was that claims with modifier TU have been removed per guidance from the Department. The TU modifier is a flag that indicates ARPA funding.

Table 5.10 summarizes the payment comparison and estimated fiscal impact.

Table 5.10: HCBS Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	76.45%
*Colorado Repriced Amount	$853,017,986
Benchmark Repriced Amount	$1,115,784,164
Est. FY23 Total Fund Impact	$262,766,178

** Colorado repriced amount is net of TPL and copayments after the cost-of-living adjustment was applied, where applicable. The cost-of-living adjustment only applies when the comparator is an average of other states' Medicaid rates.*

Table 5.10 can be interpreted to mean that for HCBS under review, Colorado Medicaid pays an estimated 76.45% of the Benchmark. Had Colorado Medicaid reimbursed at 100.0% of the Benchmark rates in FY23, the estimated impact to the Total Fund would be $262,766,178. Detailed comparison results can be found in Appendix A3 on the |2024 MPRRAC HCBS| tab, where services are grouped both by waiver program as well as waiver service category.