Appendix E - Stakeholder Feedback

Appendix E contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings. Email feedback below is verbatim and unaltered from public stakeholders and did not undergo editing or factual verification by HCPF. All verbal feedback has been summarized to the best of HCPF's ability. The feedback below does not reflect HCPF's views and opinions on the rates of the Cycle 2 Services under review.

The feedback in this appendix was collected from December 2023 through October 1, 2024.

All meeting recordings and meeting minutes can be found on HCPF's Rate Review website.

Emergency Medical Transportation (EMT)

No public feedback was received between December 2023 through October 1, 2024.

Non-Emergent Medical Transportation (NEMT)

No public feedback was received between December 2023 through October 1, 2024.

Qualified Residential Treatment Programs (QRTP)

Claire Cronin
TGTHR

Dear Rate Review Team,

Thank you again for sharing your presentation with us on the rate review process. Please see the attached document with our feedback on rates for QRTP programs.

What is Chase House?
Chase House is an inclusive, Qualified Residential Treatment Program (QRTP) supporting youth in the child welfare system offered by TGTHR. We provide a home-like atmosphere where youth access developmentally appropriate, therapeutic support while attending school and other activities in the community. We are a touch-free, non-locked facility where youth can build life, emotional, communication, and interpersonal skills. Our substance use program supports youth actively in recovery with several months of sobriety who do not require in-patient rehab.

Who is best supported at Chase House?
Chase House supports youth ages 12-18 years old who are funded by QRTP that require out-of-home placement. We specialize in supporting youth diagnosed with ADD/ADHD,oppositional defiant disorder, mood disorder, attachment difficulties, depression, anxiety, and post-traumatic stress disorder. Our participants are independent and enjoy engaging in community activities including school, meeting with professionals, and “prosocial” events. They also actively engage in healing and growth programs that help them and achieve their goals.

What therapeutic services are provided?
Youth are required to actively participate in their healing and growth. Chase House creates individualized plans designed to meet each youth’s unique needs. These include individual, family, and group therapy; art, play, talk, and equine therapy; outdoor experiential therapy; and substance abuse treatment. All youth are required to engage in a full mental health and substance use assessment.

What other services do we provide?

- Milieu management

- Weekly psychosocial groups
- Weekly processing groups
- House meetings
- Daily/weekly recreational activities
- Daily/weekly prosocial outings
- Abstinence monitoring
- Behavioral planning/monitoring
- Weekly case management services
- Medication monitoring
- Medical/dental/optical services
- Scheduling and transportation

What services do we not provide?

- Detox
- In-patient substance use treatment
- Intensive outpatient treatment
- Locked facility
- Physical restraint-based interventions
- Bathing/toileting services
- Continuous medical support/supervision

Who is not appropriate for Chase house?

- Youth charged with violent crimes against another person such as assault with a deadly weapon, murder, manslaughter, aggravated assault, and vehicular assault or homicide.
- Sexually offending youth who have an open investigation or case with Dept. of Social Services/judicial system or where an investigation has confirmed sexual perpetration allegations and have not had Sex Offender Specific Treatment.
- Youth with who are physically aggressive toward staff or peers.
- Youth who need in-patient substance use treatment, who are actively using substances with a high rate of overdose or withdrawal (i.e. fentanyl, methamphetamines, etc.), or who have overdosed on a substance within the past 30 days.
- Youth with active reported and legal documentation of current gang involvement.
- Youth with cognitive delays or IDD who are unable to abide by and comprehend structural components of the program.
- Youth who are not able or willing to engage in community-based interventions like attending school in the community, engaging in after-school activities, attending medical appointments.
- Youth who are not willing to engage in mental health programs including weekly individual therapy, group therapy, family therapy and prosocial outings.
- Youth with any infectious and contagious diseases including but not limited to HIV, chicken pox, lice, mumps, measles, rubella, the infectious stages of tuberculosis, or diabetic youth who are inconsistent in regulating their insulin and/or dietary restrictions.
- Youth who are not able to function independently (bathing, toileting, etc.).
- Youth who are supported by CYMHTA or CHRP.
- Medically fragile youth.

Who may be considered on a case by case basis?

- Youth with multiple charges/incidents related to fire starting/arson in which the youth has not received treatment or has engaged in fire starting in the past 6 months.

- Youth with a mental health diagnosis that are noncompliant in taking psychotropic medication, are not under a psychiatrist's care and have not had time to stabilize on their own.
- Youth who have demonstrated active suicidal ideation (within 24-72) hours or have homicidal plans and intent.

Current barriers to providing QRTP care

- Staffing and Competitive Wages:
    - One of the primary challenges is attracting and retaining qualified staff. Working in a residential care facility demands a specific set of skills and dedication.
    - Offering competitive wages is crucial to attract skilled professionals. However, budget constraints in the child welfare system may limit the ability to provide higher salaries, making it challenging to compete with other sectors.
    - Recently provided reports from Workforce Boulder County state the self-sufficient wage to be $32.31 per hour or $67,197 per year.
    - Rapidly increasing wages in the county make it difficult for TGTHR to pay competitive salaries

- Working within a unionized environment:
    - If the facility operates within a unionized environment, it adds another layer of complexity to personnel management.
    - Balancing the needs and rights of the workforce with the operational requirements of the facility can be challenging. Negotiating fair contracts and maintaining positive labor relations is key.
    - TGTHR invested in legal counsel for nine months to navigate the collective bargaining agreement process, which cost the organization upwards of $200,000. TGTHR had to make a large financial investment including legal representation.

- Creating a professional workforce:
    - Developing a professional workforce involves not only hiring qualified individuals but also providing continuous training and development opportunities.
    - Investing in ongoing education ensures that staff members are equipped to handle the unique challenges associated with caring for adolescents in the child welfare system.
    - There is a large financial investment in bringing in appropriate training through community partners.

- Youth with higher acuity needs:
    - Adolescents within the child welfare system often have diverse and complex needs, including emotional, behavioral, and mental health issues.
    - In response TGTHR has added a full time therapist position.
    - Tailoring programs and services to address the higher acuity needs of these youth requires a comprehensive understanding of trauma-informed care and evidence-based interventions.
    - We also have to engage and pay for community partners to provide specific treatment and prosocial opportunities

    - We have also had to make changes to our physical facilities including changing doors, adding security cameras and general maintenance which totals over $50,000.
    - There are additional costs for repairs related to property destruction related to dysregulated youth.
    - As part of the accreditation process, required to receive the QRTP certification, Chase House underwent an ADA renovation in 2019 in order to make the facility ADA accessible for young people. This project cost about $70,000.
    - We are currently facing an additional $62,500 in costs related to painting, storage,appliances,windows, new flooring, HVAC system, door framing etc.

- Staff Burnout/Turnover:
    - The nature of the work, coupled with the emotional demands of caring for adolescents with challenging backgrounds can contribute to staff burnout.
    - High turnover rates can disrupt the stability and continuity of care for the youth. Implementing strategies to support staff well-being, such as regular debriefing sessions and mental health resources are essential.
    - TGTHR has increased its benefits of employee assistance program to include mental health services in order to buffer the effects of secondary trauma for staff
    - There is a large cost associated with on-boarding and exiting employees.

As you can see, addressing these challenges requires a multifaceted approach that involves collaboration with stakeholders, adequate funding, and a commitment to creating a supportive and professional work environment. We hope this document will illustrate some, but not all of the costs associated with running a quality QRTP.

Psychiatric Residential Treatment Programs (PRTF)

No public feedback was received between December 2023 through October 1, 2024.

Physician Services - Sleep Studies

No public feedback was received between December 2023 through October 1, 2024.

Physician Services - EEG Ambulatory Monitoring Codes

No public feedback was received between December 2023 through October 1, 2024.

Fee-for-service (FFS) Behavioral Health (BH) Substance Use Disorder (SUD) Codes

Kara L. Johnson-Hufford, MPA
Colorado Behavioral Healthcare Council | CBHC

Thank you for your patience in my additional response. I wanted to do some additional homework and outreach to our National Council contacts about your ask. In looking at other FFS states, below is information from Maine and Connecticut that may helpful. Our National Council contacts checked with Dr. Parks, who leads the Medical Directors Institute and formerly led Missouri Medicaid and he shared this article that may be of interest.

Maine recently put a new system of rate review and reform in place. Here is a link to an article and website on it -

https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform. And here is a ME HHS blog that has several posts regarding it -

https://www.maine.Hegov/dhhs/blog.

Connecticut

- CT Mental Health & Addiction Services sending can be found here
- CT Human Services spending which includes Medicaid generally and some other related groups is available here.
- Specific BH rate increases are reflected in this December 2022 provider bulletin
- A 4% rate increase in fall 2021 is outlined in a SPA submission here and was approved.

This survey released by KFF in November includes a map that illustrates which states had rate increases for 2023/2024. The article notes following about halfway down the page:
Some states noted rate increases were targeted to specific provider types, such as increases for Substance Use Disorder (SUD) service providers (including outpatient and institutional providers), psychotherapy/counseling providers, or for applied behavioral analysis (ABA) providers. Other states implemented increases that were more widespread. Rate increase examples include:

- ***Iowa*** *reported that behavioral health intervention providers received a 20.6% increase in FY 2023, ABA providers received an 8.9% increase in FY 2023, individual mental health practitioners will receive a 56.6% increase in FY 2024, SUD providers will receive a 96.5% increase in FY 2024, and Psychiatric Medicaid Institutions for Children will receive a 27.6% increase in FY 2024.*
- ***Nebraska*** *reported across the board behavioral health rate increases of 17% in FY 2023 and 3% in FY 2024.*
- ***New Mexico*** *reported increasing FY 2024 behavioral health rates to 120% of Medicare and plans to review rates annually in the future.*
- ***Oregon*** *reported an aggregate increase of 30% for behavioral health services by procedure code in FY 2023. The state focused on SUD, behavioral health outpatient, ABA, peer support, and residential services.*

- ***South Dakota*** *reported 16% increases for SUD and Community Mental Health Center (CMHC) providers and a 5% inflationary increase for other behavioral health services in FY 2023.*
- ***Vermont*** *reported mental health providers received an 8% rate increase in FY 2023 and a 5% rate increase in FY 2024, while SUD providers received a 5% rate increase in FY 2023 and a 5% rate increase in FY 2024.*

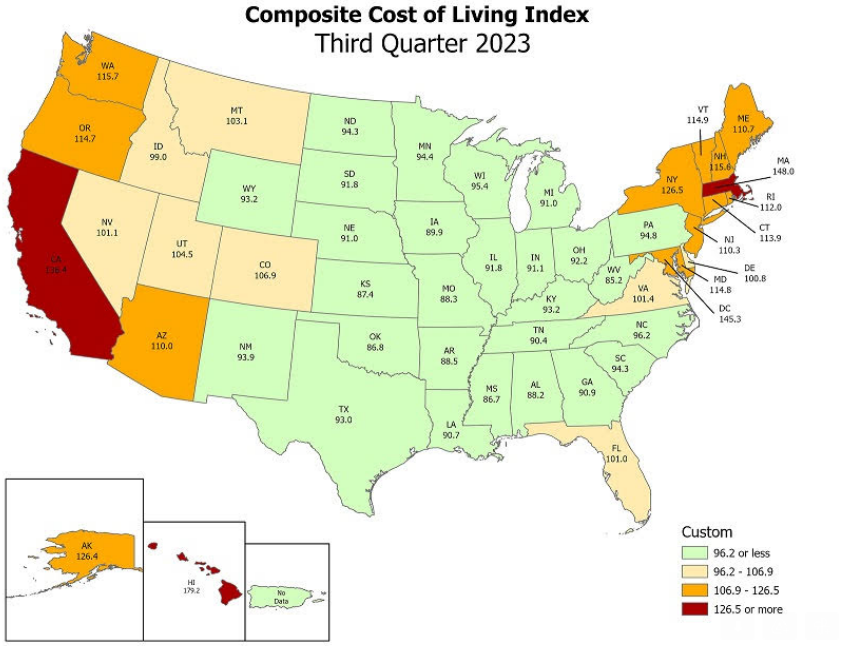
Feel free to let me know if you'd like an association contact for any of these other states where helpful. I'd be happy to connect you.

Kelly Phillips-Henry, PsyD, MBA
Aurora Mental Health & Recovery

Here is the info that we could come up with – not sure if this helps or not. We know you have access to this info as well.

Regarding carve-outs for SUD, there are 4 states and CO: Maryland, Michigan, DC, and Pennsylvania where outpatient and inpatient SUD are "always carved out". Several others report that it varies, but for most states the benefit is "always carved in". From KFF 2021 https://www.kff.org/report-section/state-policies-expanding-access-to-behavioral-health-care-in-medicaid-appendices/

Regarding cost of care, I would guess that states that have a similar cost of living might be good comparisons. Here is a map of COL by state. There is a table that breaks this down- you can look at just cost of healthcare: https://meric.mo.gov/data/cost-living-data-series



COLORADO
Department of Health Care Policy & Financing

Home Health Services

Joe Giauque
Comfort Keepers

Thank you for including me in this. I would love to attend the meeting and I'm eager to see when it hits the schedule.

At the moment, my primary concern is the repeated practice of tying every rate increase to an increase in a caregiving minimum wage. For my agency, I believe I can summarize it in two issues.

1. When a rate increase is tied directly to a caregiver minimum wage increase, it does not consider the ancillary costs that also rise, such as FAMLI, Work Comp, SUTA/FUTA, Sick time, etc. It doesn't need to be exact, but there is no accounting for additional associated costs at all. To do that once is perhaps less than ideal but can be workable. To do it every time begins to create a net loss that cannot be overcome indefinitely.

2. In my agency, it is a very limiting practice. Of course the margins on Medicaid work are thin.However, increasing the minimum that must be paid beyond already established minimum wages eats into that thin margin in a way that prevents me from rewarding better caregivers. It is difficult to pay much more than the bottom wage, so there is not enough revenue left to properly reward those with 1. Experience/longevity 2. Great performance 3. Additional education/licensure. We do compensate extra on these 3 metrics, but the difference is relatively small compared to those are new/performing poorly because we are squeezed on both ends (the bottom is the caregiving min wage and the top is the rate reimbursed).

Donna Moore
Nurture Home Health Care

PTs, OTs, and SLPs also provide home health services. They do not appear to be listed as outliers at this time so are not being addressed. These skilled services require a skilled clinician, which cannot be provided by a CNA. With that said, therapy service reimbursement will be impacted by this

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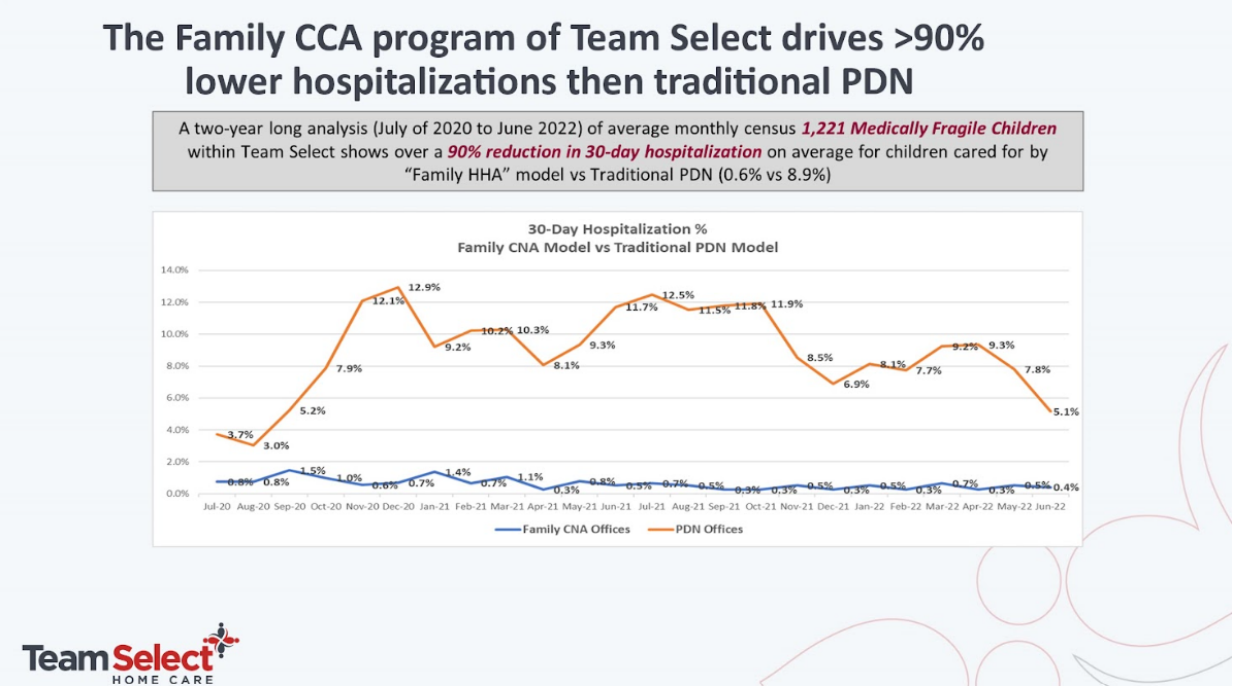
Pediatric Personal Care (PPC)

No public feedback was received between December 2023 through October 1, 2024.

Private Duty Nursing (PDN)

Bill Sczepanksi
Team Select Home Care

When reviewing PDN rates for Colorado, please review this Excel sheet, which shows the PDN rates of all the other states. Please look at their rates and how some states, like MA, have differentials for shifts, like hospitals, when paying nurses for shift differentials. I appreciate your consideration. Here is a chart on hospitalizations. The reason why the hospitalization rate is lower with Parent CNA clients is because they have consistent staffing compared to PDN because Parent CNA allows us to use family members. To get consistent staffing in PDN we must raise provider rates so PDN providers can recruit nurses who work in facilities.



Email attachment(s):

- PDN Rates by States 2024-NP

Jim Melancon
Aveanna

Attached please find a copy of the information that I will be speaking to during my public testimony today. As always, I am always happy to review and discuss further with you.

Email attachment(s):

- CO MPRRAC State Medicaid PDN Rate Comparison

Eliza Shultz
Shultz Public Affairs, LLC
Here's the study we commissioned to look at the PDN rates. Additionally, here are the rates in all states in one table.

Email attachment(s):
- ELIZA SHULTZ ATTACHMENT 1 - PDN rates by States 2023-NP

Julie Ruskin
Colorado Cross-Disability Coalition
Thanks for reaching out, Please let me know when there are specific dates. I represent the client community, not the provider community and we are often left out of these important conversations so appreciate that you emailed. I am not sure about which states to reach out to, but the bigger issue is that it may be hard to find this because Colorado has a pretty unique model with our nurse practice act and how it is implemented is really discouraging using lower levels of care. While delegation is technically allowed, it is not used much because of how the CDPHE implements. Not allowing children to have CDASS also drives the need for PDN. If they had CDASS there is one rate for skilled care--the children who have PDN level needs are not going to be served by home health agencies under the CNA program. Home health agencies mostly only take clients who have family caregivers, forcing more people into PDN if they do not have family members that are basically unemployed and unemployable

because of how unreliable the service is. Nursing, while suffering from severe staff shortages, is at least reliable. They tend to not no show/no call.
When you look at other states, look at their delegation laws and practices. Also, look at rules around home health agencies, are they allowed to pick and choose clients or are there contracts requiring specific service amounts, Also, I would look at states that have personal care as a state benefit and see what the pay is and if it is high enough to serve these complex and medically involved kids.
Let me know if you have questions.

Matt Hensen
Civic Management
I apologize for the delay in getting back to you with the requested information. It has taken some time to research. Hopefully the information was worth the wait.
We would recommend only using fee-for-service states as your comparison because not only do the MCO states have differentiated negotiated rates, but they also have limited networks,

prior auth requirements, and other issues that make it challenging to use them as a reference point. With that said, the following suggested states are all fee-for-service for the majority of the services you're looking into:

- Oregon: has a similar population dynamic with one large city, a few smaller ones, and then large rural/frontier areas. Generally speaking, has a similar view of government programs to CO.
- Washington: On the wealthier end of the spectrum with a larger population, but their lack of a state income tax does tend to limit overall expenditures. Some managed care, but not for the majority of services in your comparison.
- Maine: Fully fee-for-service, aging population, and heavily rural areas. Portland (ME) doesn't quite compare to Denver but does create some similar population dynamics. Maine had a prior governor who emphasized restricting government spending but the new administration is a bit more willing to spend on programs.
- Utah: Geographic proximity makes for a good comparison, coupled with the same urban/rural dynamics. I'm very familiar with Utah, and though they tend to be more fiscally conservative than CO and OR with funding, they are poised to receive a significant increase to HCBS rates during the 2024 Legislative Session, as it was Medicaid's #2 priority and included in the Governor's proposed budget.
- Idaho: Another mountain-area state with heavy urban/rural split. Similar to Utah, they're restrictive on their view of the role of Government but have similar dynamics.
- Wyoming: Bordering state with some similarities in geography. Fully fee-for-service, but no real urban areas comparable to Denver.
- Nebraska: Bordering state with some similarities in geography. Mostly fee-for-service, but no real urban areas comparable to Denver.

I have attached the most recent compilation of PDN rates from around the country that was developed by Team Select and augmented by a few other groups, including the National Association for Home Care and Hospice (NAHC). I'm also attached the most-recent version of the NAHC rate compilation. It's not updated for every state, but it's the most recent compilation of all of these different service types that I'm aware of:
Please let me know if you have any further questions or if I can help in any other way!

Email attachment(s):

- Matt Hanson attachment 1 - MASTER DOCUMENT - Rate survey results 2023
- Matt Hansen attachment 2 PDN rates by States 2023-Team Select and NAHC

The Menges Report
Submitted by multiple public stakeholders
The Menges Report can be downloaded by clicking this link.

Catherine Morrison
Maxim Healthcare Services

Maxim Healthcare Services is a national provider of skilled nursing services, including private duty nursing. In Colorado, we operate five offices, have over 800 patients and employ nearly 900 caregivers.

We urge the MPRRAC to meaningful increase Medicaid rate reimbursement for PDN services in order to increase patient access to care, improve the quality of life for patients and their families, and reduce hospitalizations.

The Menges Group was enlisted by the Home Care and Hospice Association of Colorado (HHAC) to evaluate the state's Medicaid Private Duty Nursing (PDN) payment rates. The report found that Colorado's Medicaid payment rates for PDN services are lower than typical Medicaid rates nationally, and even average Medicaid payment rates are below the amounts needed to attract and retain nurses into the PDN sector. Many different types of organizations compete for nurses, and the state's Medicaid rates put PDN providers at a significant disadvantage. Colorado falls short in the supply of PDN labor available to support its Medicaid enrollees. The analysis recommends a 37.8 percent increase for RNs and 52.1 percent increase for LPNs, respectively.

Along with HHAC, we are eager to share the full report results and respectfully request time a future meeting to do so.

Erica Drury
MGA Homecare

These rates are challenging to recruit and retain a direct care workforce with the minimum wage hikes in many counties throughout the state.

Edie Busam
Aveanna Healthcare/ Aponte Busam Public Affairs

Good Day Committee MPRACC Members
My name is Edie Busam, lobbyist representing Aveanna Healthcare and a former nurse who has clinically worked in emergency services, nursing administration, and hospice.

We have spent serious time discussing rates. Looking at the numbers is always important, however what I feel we need to be continually reminded, is this is patient care of very difficult kiddos who need specialized care and if this PDN care is not available could be candidates for hospital care. In fact, there are children languishing in the hospital for years, never having been in their family home, for lack of nursing"

Giving these wonderful children the opportunity to be with family is vital. Parents need to be supported as well.

Nursing staff committed to taking care of these patients are a rare commodity as the delivery

of care in the home requires a unique independent professional. This nurse has to be creative and confident in their skills as there is not the support of a colleague on the floor to come assist as in a hospital facility. Our wages need to reflect this ICU critical care work in the home.

As you have these discussions, please think about this care and how necessary attracting these professionals to the home is imperative. There are families and children waiting to be in their homes, but we are unable to meet this need.

Thank you for your thoughtful consideration of this needed increase. Other states have seen this need, we need to do the same in Colorado.

Erica Drury
MGA Homecare

Please provide the Menges Report that was prepared earlier this year to the MPRRAC and the HCPF MPRRAC team. We would like to request that Georgia be included in the comparison states as well as review the recent rate increases reviewed by past comparison states that are no longer included in the analysis. Thank you for the opportunity to comment.

Jim Melancon
Aveanna Healthcare

I would like to offer comments on Private Duty Nursing services.

Home & Community Based Services (HCBS) - ALL CATEGORIES

This section contains feedback from all providers that represent the HCBS community. Many providers from this community represent several types of HCBS services; therefore, feedback is not separated out into different categories and is instead listed by provider.

Andrea LaRew
Colorado Chiropractic Association

I am sorry for the late email! I think I mentioned we had an all-day board retreat today, followed by a dinner. I've attached some information for you. It looks like a lot, but the majority of it is a research document from Missouri. Most states I connected with have chiropractic care as part of the state plan, and not on a waiver.

Please let me know if you have any questions, or if you need anything else from me at this time. I will be sure to look up the 2024 meeting information and we will share that with our members.

Thank you!

Email attachment(S):

- Andrea LaRew attachment

Chanda Hinton
Chanda Center for Health

Thank you in advance for reviewing our request. To support our request, attached you will find:

1. CCFH Recommendation to MPRRAC, which is our formal request with detailed information supporting the need for provide rate increases, supported by additional data (supplementary attachments)
2. CIH Waiver Evaluation Reports for 2022 and 2023
3. CCFH 2023 Evaluation and Outcome Report
4. Local State of CO Rate Analysis

Please let us know if you have any questions. We look forward to seeing rate increase for chiropractic, massage, and acupuncture via all Medicaid waivers, especially the CIH Waiver for purposes of continued cost savings, improved quality of life, increase provider enrollment and support providers serving complex populations.

Email attachment(s):

- Chanda Center Formal Provider Rate Increase Request - 2
- Chanda Center Formal Provider Rate Increase Request - 3
- Chanda Center Formal Provider Rate Increase Request - 4
- Chanda Center Formal Provider Rate Increase Request - 5

Deborah Lively
LeadingAge Colorado

Thank you, Michelle. I will be sure to let our members know about the MPRRAC meetings in 2024 and I will participate as well. In terms of other states – when it comes to HCBS I think it is more difficult because the programs and reimbursement are so different. For example, some other states don't offer assisted living as part of their Medicaid programs, or the reimbursement rates are so low there is very limited access. I will do some research and reach out to our national partners and let you know what I learn.

Ellen Jensby
Alliance

Thank you all for your work to prepare the MPRRAC to make recommendations on HCBS. It is quite an undertaking! Given their interest in more detailed feedback from the community, I have a number of questions that I'm hoping you can answer to assist us with better understanding the benchmark analysis:

- Can you share more data about where services/codes within the HCBS categories landed with respect to the benchmark? Currently, we can only see where the outliers landed, but knowing how the rest of the services/codes lined up is important too.
    - We would also like to know which services/codes had no comparable state data to develop a benchmark.
- What were the characteristics that you felt made these 10 states good comparisons for Colorado?
- Was there analysis for the provider/regulatory requirements when comparing services across states (for example, licensure requirements or absence thereof compared to CO, which could skew the analysis)?
- Will we be able to see how many of the states were used to develop the benchmark rate for a given service? E.g., for individualized Supported Community Connector, did all 10 states have a comparable service, or only some of them?
- Re: the HCBS Categories with Services Appendix:
    - Why is CDASS in ADL Assistance but also has its own category?
    - Same for Respite.
    - Why are RHSS/IRSS/GRSS all listed under Community Access & Integration and also under Residential?

Thank you for your help!

To: Members of the Medicaid Provider Rate Review Advisory Committee
From: Ellen Jensby, Senior Director of Public Policy & Operations at Alliance
Date: July 11, 2024

Re: Additional Comments and Recommendations on HCBS Rate Review

Alliance respectfully submits the following additional feedback and recommendations on behalf of HCBS providers serving Coloradans with Intellectual and Developmental Disabilities (IDD). We may have revised input as we continue to review the significant amount of data posted two days ahead of the meeting.

Below, we outline recommendations for each service that we hope to target through the MPRRAC process. We have chosen these services because providers report a lack of capacity relative to community needs, resulting in access barriers for people with IDD and their families.

Ongoing Concerns Related to Process and Methodology
Alliance members continue to have serious reservations about the methodology of a state-to-state benchmark analysis in HCBS. We also have concerns about the

overall process used to review HCBS. These concerns include but are not limited to the following:

- As demonstrated by the fact that approximately 50% of HCBS codes do not have a benchmark, HCBS vary widely from state to state and it's difficult to make apples-to-apples comparisons. We were unaware of HCPF's efforts to gather stakeholder input about appropriate benchmark states and never saw any announcements about this work via the typical channels.
- The public was not able to see the full list of benchmarks for each service until very late in the stakeholder process, hampering our ability to research the accuracy of the benchmark. • As noted in our initial comments, reviewing all HCBS in a single year along with other services is simply unrealistic. The process has proven overwhelming for both MPRRAC members and stakeholders, and time is inadequate to meaningfully evaluate each service. • While we appreciate HCPF's efforts to collect and analyze the benchmark data, stakeholders would have greatly benefitted from having access to this data at the March public meeting so that we could digest, ask questions about, and evaluate it in order to provide meaningful input.
- As we reviewed the data posted on Wednesday, our overall take-away was that much of it does not match provider experience on the ground. We feel that additional data on the cost to deliver services and service access should be part of the analysis and that any recommendations the MPRRAC makes based solely on the benchmark analysis are likely to be, at best, imprecise, and, at worst, inaccurate.

Despite these reservations, we understand that the MPRRAC relies upon stakeholder feedback to fulfill its statutory obligation. Therefore, we have crafted recommendations that reflect what providers feel would be needed to sustain the following services.

MPRRAC's Benchmark Goal for HCBS

Despite our reservations about the benchmark analysis, we recognize that this is the data MPRRAC is working with. Therefore, we recommend that any codes within the services listed below that fall below 100% of the benchmark established by MPRRAC should be increased to 100% of the benchmark. We believe HCBS should be funded at 100% of benchmark rather than the 80% goal articulated by the MPRRAC because:

- HCBS are alternatives to expensive institutional settings that people with disabilities would otherwise require, such as nursing facilities and hospitals. Therefore, they are inherently cost saving.
- The vast majority of IDD providers are almost entirely reliant on Medicaid reimbursements for their revenues because Medicaid is the sole payor. When rates for services are inadequate to cover costs, providers cannot raise their revenues to cover losses and, therefore, must reduce or discontinue services, resulting in access issues for people with IDD.

Recommendations on Specific Services:

ADL Assistance and Delivery Models

Alliance supports the MPRRAC recommendation to align disparate rates for Personal Care and Basic Homemaker services, which will improve the rate for Basic Homemaker. Because Personal Care on the IDD waivers is already the highest existing rate for that service, IDD providers would not receive an increase. Our members already struggle to sustain Personal Care despite receiving the highest existing rate because of the regulatory requirements.

- **Recommendation:** In addition to aligning Personal Care rates across waivers to the highest existing rate (T1019), the Outside Denver Personal Care rate should also be increased to the Denver rate of $7.73/unit.
- **Policy Recommendation:** HCPF and the Colorado Department of Public Health and Environment should find ways to ease the administrative burdens of providing Personal Care to make the rate more sustainable and increase provider participation.

Behavioral Services

The benchmark data for Behavioral Consultation does not match the experience of providers on the ground who report that they cannot hire and retain qualified personnel at the existing rate.

- **Recommendations:**
  - o Increase the rate for Behavioral Line Staff (H2019) to the rate for a Registered Behavioral Technician within EPSDT (specific service and code will be clarified in follow-up communication).
  - o Behavioral Plan Assessment (T2024), Behavioral Consultation & Individual Counseling (H2019) should be increased from $110/hr to $125/hr.
- **Policy Recommendation:** Create a new rate for counseling two people. Providers see a need to help people with IDD resolve conflicts, whether couples, roommates, or otherwise. The Group Counseling (H2019) rate currently works well for groups of 3 or more but is too low to support only two people in a session.

Community Access & Integration

HCPF's benchmark analysis findings for Individual Job Development do not match provider experience. They report it is very difficult to provide this service at the existing rate. This experience was borne out in an independent rate study completed by a national Support Employment subject matter expert who studied Colorado provider costs.

- **Recommendation:**
  - o Increase Job Development (H2023) rates by at least 33%.
  - o Increase any Job Coaching (T2019) support levels that are below benchmark to 100% of benchmark.

Day Program

We were surprised to see that Supported Community Connections had no benchmark data and confused by the benchmark data presented for Specialized Habilitation. *E.g.*, Specialized Habilitation Level 1 Outside Denver is 17.87% of benchmark at $3.64/unit, but Level 2 is at 123.5% of benchmark at $3.92, just a 28-cent difference. This suggests that the benchmark data provided a very small range of rates for this service. Even though some Specialized Habilitation codes fall above 100% of the benchmark, providers report that rates are insufficient to support staffing levels that result in a high-quality service. The data does not match provider experience.

We still do not know if the staffing ratios from other states match what Colorado providers are doing and therefore whether their rates are an apples-to-apples comparison.

- **Recommendations:**
    - o Increase Specialized Habilitation (T2021) and Supported Community Connections (T2021, tiers 1 and 2) by at least 25% to support staffing smaller groups, resulting in higher-quality services that align with modern expectations and best practices. Providers suggest this is the increase needed to break even on this service.
    - o Increase the rate for Individualized Supported Community Connections (T2021 Tier 3) by 52% to align with a similar service on the CES waiver, Community Connector. Increasingly, people with IDD and their families are requesting individualized services because they are less stigmatizing and higher quality.
- **Policy Recommendation**: Remove Individualized Supported Community Connections (Tier 3) from the Support Plan Authorization Limit (SPAL) in order to allow members to access more units of this service. Currently, the SPAL significantly limits access to this service and raising the rate will result in even fewer hours of service due to the SPAL.

Professional Services

Recommendations:

- Increase Massage Therapy (97124) by 19%. Although HCPF's analysis found that massage rates were at 109% of the benchmark, providers report that they have extreme difficulty recruiting and retaining massage therapists at the existing rates because other employers can pay them a lot more.

• Increase Music and Movement Therapies (H2032, G0176) by 39%. Given the lack of benchmark data, the MPRRAC should rely upon cost data provided by stakeholders. • Increase Bereavement Counseling and Therapeutic Life Limiting Illness Support (S0257) services by at least 5% to accommodate a larger eligible population. Soon, HCPF will merge the Children's Life Limiting Illness population which currently offers these services with another, larger waiver, increasing the number of children who will become eligible for these services. The current rates do not support the workforce

needed to serve a much larger population.

Residential

Alliance members report that Group Residential rates are insufficient to operate group homes despite recent targeted increases to sustain them. While HCPF's analysis found these rates to be around 100% of the benchmark, we would like to dig into the benchmark states to make sure they are good comparisons in terms of home size, regulatory standards, and other qualities. Again, the data does not match provider experience.

- **Recommendation:** Increase Group Residential Services and Supports (T2016) rates for support levels 1-6 by at least 10%.

Respite

Although many Respite codes are showing at or above benchmark, providers report struggling to provide this service in a timely manner. It is one of the most highly requested services by families.

- **Recommendation:** Increase unit-based Respite rates on the DD, SLS, and CES (S5150) waivers to align with the Denver Personal Care (T1019) rate of $7.73/unit (in turn, this will affect the daily rate which is based on the unit rate). Because Respite is often similar to Personal Care in terms of how it is provided, we recommend adopting the same rate.

Joe Giauque

Thank you for including me in this. I would love to attend the meeting and I'm eager to see when it hits the schedule. At the moment, my primary concern is the repeated practice of tying every rate increase to an increase in a caregiving minimum wage. For my agency, I believe I can summarize it in two issues.

1. When a rate increase is tied directly to a caregiver minimum wage increase, it does not consider the ancillary costs that also rise, such as FAMLI, Work Comp, SUTA/FUTA, Sick time, etc. It doesn't need to be exact, but there is no accounting for additional associated costs at all. To do that once is perhaps less than ideal but can be workable. To do it every time begins to create a net loss that cannot be overcome indefinitely.
2. In my agency, it is a very limiting practice. Of course the margins on Medicaid work are thin. However, increasing the minimum that must be paid beyond already established minimum wages eats into that thin margin in a way that prevents me from rewarding better caregivers. It is difficult to pay much more than the bottom wage, so there is not enough revenue left to properly reward those with 1. Experience/longevity 2. Great performance 3. Additional education/licensure. We do compensate extra on these 3 metrics, but the difference is relatively small compared to those are new/performing poorly because we are squeezed on both ends (the bottom is the caregiving min wage and the top is the rate reimbursed).

Maria Jasso
Alliance

Dear MPRRAC members,

Alliance would like to offer the attached document for your consideration as you review rates for Home and Community-Based Services (HCBS). Alliance is a statewide, non-profit association of Case Management Agencies, Community Centered Boards, and HCBS Provider Agencies serving primarily Coloradans with intellectual and developmental disabilities (IDD) and these comments reflect the experience of our IDD provider members.

We hope that this information helps to inform the MPRRAC's analysis of HCBS rates. After your June meeting and presentation of more detailed data, we hope to provide additional information, responses, and recommendations.

To: Members of the Medicaid Provider Rate Review Advisory Committee
From: Ellen Jensby, Senior Director of Public Policy & Operations at Alliance Date: June 10, 2024

Re: Alliance Comments on HCBS Rate Review

Dear MPRRAC members,

Alliance is pleased to offer the following comments for your consideration as you review rates for Home and Community-Based Services (HCBS). Alliance is a statewide, non-profit association of Case Management Agencies, Community Centered Boards, and HCBS Provider Agencies serving primarily Coloradans with intellectual and developmental disabilities (IDD). These comments will
reflect the experience of our IDD provider members while referencing the Colorado HCBS provider rates for Fiscal Year 2023-24.

General Comments:

HCBS and IDD Providers are Unique within Medicaid

As you know, HCBS are distinct from other Medicaid services in several ways, most notably that many of the services are not covered by other payors such as private insurance and Medicare, making establishing an appropriate benchmark challenging. Additionally, IDD providers are distinct from other Medicaid provider types in that they rely almost exclusively on Medicaid reimbursement for their revenues. Many of our provider members report that Medicaid makes up 90% or more of their revenue. The rest is typically made up of fundraising or other small contracts, typically from other government sources.

Because people with IDD are typically impoverished, there are very few people who can afford to privately pay for HCBS. And, of course, providers are prohibited from balance billing (nor would this be practical or desirable). As a result, when Medicaid rates are inadequate, IDD provider agencies have no way to increase their revenues to cover rising costs outside of private fundraising. The result is that they reduce the amount of certain services they offer or decline to offer them altogether, leaving service gaps for people with IDD and their families.

Interplay with Budget Neutrality Factors

We applaud HCPF for its recent efforts to sustain IDD services. The implementation of a base wage for Direct Care Workers and the resulting annual rate increases for these services, as well as some significant targeted increases in recent years, have reduced the ground lost in our environment of rising wages and other costs. While these increases have been incredibly helpful, some of these rates have carried positive "Budget Neutrality Factors" (BNFs) for years, meaning that the rate paid is not as high as HCPF's rate methodology says it should be. To be specific, HCPF's rate methodology calculates a certain rate for the service based on cost inputs, but if the General Assembly has not appropriated enough funding to support that rate, the rate is set artificially low to accommodate available funding. The difference between what the rate *is* and what it *should be* is the Budget Neutrality Factor. In other words, the rate is already not fully covering the cost to deliver the service based on HCPF's calculations.

Because base wage increases are only designed to cover the increase in the base wage, not make the rate "whole" from the perspective of HCPF's rate methodology, these increases have not been sufficient to close the BNF in many cases. We strongly encourage the MPRRAC to explore BNFs and take them into account in their recommendations, but we also have a word of caution: the rates for some HCBS have not been rebased in some time, which means that the rate recommended by HCPF's rate methodology still may not account for changes in how the service is delivered or other cost drivers that have emerged since the rate was last rebased (*e.g.*, cybersecurity infrastructure or smaller staffing ratios). Therefore, even if a service has a zero or negative BNF (meaning it is theoretically adequate or overpaid according to the rate methodology), it may still be too low to cover costs.

Where analysis of the BNFs and other state comparisons are inconsistent with provider experience, we urge the MPRRAC to heed provider experience given the imperfections of the data.

Challenges of State-to-State Comparisons in HCBS

In our work within national IDD provider associations, we know that our funding challenges are not unique. Across the nation, IDD providers continue to struggle with decades-long workforce challenges, and many report service reductions or closures due to inadequate funding, especially since the pandemic. Colorado was one of the leaders nationwide in its efforts to protect HCBS during the pandemic, and many other states are still trying to recover. Therefore, using a state-to state comparison approach to determine whether HCBS rates are adequately funded comes with the potential risk that we may be comparing ourselves to states that also have low funding levels, keeping us in a cycle of under-funding.

We know that HCPF identified 10 other states against which to compare Colorado's rates. We do not yet know the specific characteristics of these states and why HCPF felt they were a good comparison. We anticipate learning more at the June meeting, but we anticipate that we will not have information on some metrics which we feel are very important when comparing services and rates across states, including:

- Do the comparison states have adequate service **access**, meaning that there are a sufficient number of providers offering the services for people who need them? In Colorado, we know there are service gaps within the services we will highlight below.
- Do the comparison states have good service **quality**? Is funding adequate to recruit, retain, and train qualified staff? Is there a high degree of turnover among Direct

Support Professionals? Does the state rely on congregate service models for certain services, or are they doing smaller groups and more individualized services like Colorado?

- Are the **regulatory requirements** more or less stringent than they are in Colorado, affecting the cost to deliver the service?

Challenges for Stakeholders in Commenting on HCBS

Lack of Data

In communicating with HCPF staff since the March 29th public MPRRAC meeting, we understand that more detailed data will be presented at the June meeting. We look forward to reviewing this data, but want to state for the record that not having all the details available at the beginning of the window for stakeholder engagement puts us behind in our ability to respond and provide data from Colorado providers that may either support or rebut the findings from state comparisons. We were surprised to learn that half of Colorado's HCBS had no benchmark comparison in other states. If we had a breakdown of which services these were, we could have collected more data on them to inform the MPRRAC.

Service Categories Obscured Initial Analysis

We understand that there are a lot of services within the umbrella of HCBS and appreciate the department's attempt to organize the work by putting them into categories. However, this also obscured the analysis because we were unable to see how individual services compared to the baseline, or how far off they were. For example, the services presented in the "Community Access & Integration" category are not necessarily all similar to each other. Combining them for purposes of the initial benchmark analysis without a more detailed breakdown of each service left us with more questions than answers. We understand this breakdown will be forthcoming, which we appreciate.

Too Many Services to Review at Once

For future HCBS analyses, the MPRRAC should consider reviewing individual services or categories of similar services at different times during its multi-year review cycle, rather than all HCBS in the same year. While all offered under the same Medicaid authority, the services are incredibly varied and distinct. Personal Care is very different from Job Coaching. Day Habilitation is very different from Massage Therapy. Behavioral Services are very different from Residential. Trying to review them all at once reduces the MPRRAC's ability to understand and meaningfully evaluate each service due to time constraints. It's simply too many services to bucket together for meaningful consideration.

Comments on Specific Services

The following services are those that our members consistently report are under-funded and have resulting service gaps. We recently conducted a survey of members to offer the data presented in these comments. We are grateful to our members who responded to the survey despite the extraordinary workload they are under due to major systems changes within HCBS. These events reduced the number of responses we would normally expect from a survey.

We also want to emphasize that staffing is the single biggest cost for most of the services below. Therefore, we collected some data from members on the average cost to employ Direct Support Professionals (DSPs), when taking into account not just the wage, but other employer costs such as benefits, oversight and training, and overhead (insurance, technology, etc.). Based on

responses to our survey, the average hourly cost to employ a DSP when accounting for these factors is $31.76. Below, we highlight the difference between rates paid and this average relative to specific services. The rates we cite are those posted as of May 1, 2024 and do not include increases approved for the 2024-2025 state fiscal year, as they have not been published as of the date of these comments.

Personal Care & Basic Homemaker

These services exist on multiple waivers, and HCPF is in the process of moving them out of the waivers and into the Medicaid State Plan. To do so, they have to create a single rate for each service rather than the different rates currently paid under various waiver programs.

Our members provide these services mainly under the Supported Living Services (SLS) waiver. Although the SLS rate for Personal Care is one of the highest, members have long reported that they struggle to break even on it. We know of a number of members that have discontinued providing Personal Care in recent years or are considering discontinuing it in the near future, despite it being one of the most sought-after services from individuals and families. One of the major complaints about Personal Care is that the administrative burdens associated with licensure requirements are so time-consuming and costly that the rate can't support the cost to deliver the service, or providers struggle to break even. The hourly rate for Personal Care on the SLS waiver is $28.30 (we used outside Denver rates, prior to the 7/1/24 rate increases, for our comparisons, given that the data we collected was representative of providers in various parts of the state). When compared to the average cost to employ a DSP of $31.76, you can see $28.30 falls well below. Furthermore, $31.76 doesn't account for the overhead associated with the licensure requirements for this service, making the rate even more insufficient.

Basic Homemaker, by contrast, receives a lower rate on the SLS waiver than on other waivers. Members also report that it is a major financial "loser". Anxiety exists among members that, as these services get moved into the state plan, some of the tasks that previously fell under Personal Care will now be housed under the lower-paid Homemaker, making it even less financially viable. Currently, the hourly rate for Basic Homemaker is $22.64, which is significantly lower than the average hourly cost to employ a DSP of $31.76 reported by our members.

At a minimum, the MPRRAC should recommend a rate for both of these services that is as high as the highest existing waiver rate currently paid, so that no provider experiences a rate cut when the services migrate to the state plan. However, the MPRRAC should also strongly consider recommending an even higher rate, especially in light of recent Medicaid regulations that, in a few years, will require 80% of the rate for these services to be spent on direct care worker compensation, leaving even less to accommodate the administrative and other costs.

Behavioral Services

Our members report that requests for these services increased during the pandemic, for obvious reasons, and have continued to be high since. Unfortunately, they also report that the rates make it

very difficult to recruit enough staff to provide the services. Responses from Alliance's recent survey showed that:

• 50% of respondents (7 out of 14) have waiting lists for Behavioral Services • Over 60% (9 out of 14) are providing fewer hours of Behavioral Services than people want/need due to staffing issues

Within the category of Behavioral Services, Behavioral Line Staff is delivered by DSPs. The current rate is $31.16 per hour, versus the average cost to employ of $31.76 per hour. The other services (Behavioral Consultation, Behavioral Counseling, and Behavioral Plan Assessment) require additional professional credentials, and members report that the rates for these services do not support compensation that is competitive with what these professionals can get paid by other employers, so they have difficulty recruiting and retaining enough staff. The MPRRAC's analysis should include information about the average pay for Board Certified Behavior Analysists and Registered Behavior Technicians to ensure that Behavioral Consultation, Behavioral Counseling, and Behavioral Plan Assessment rates are adequate.

Supported Employment

Employment is a major quality-of-life driver for people with IDD, as it can not only provide income, but also relationships, community integration, and a sense of contribution. Research shows it can also improve people's health and independence, reducing the need for paid services in other areas. Specifically, research has demonstrated that, for every $1.00 invested in supported employment, taxpayers receive $1.46 back in taxes paid, reduction in government subsidies, and foregone costs of alternative programs. Therefore, employment supports offer a good return on investment of Medicaid dollars. Expanding competitive, integrated employment for people with disabilities is a goal in Colorado as well as nationally, with many state and federal initiatives. However, we have not seen significant growth in providers who offer these services due to funding.

Supported Employment services encompass several distinct services, including Job Coaching and Job Development. We consistently hear that the rates for Job Coaching and Job Development make it difficult for providers to break even on these services. An independent rate study completed by a national subject matter expert contracted by the Colorado Office of Employment First in 2022 recommended increases to these services when provided on an individual basis. The expert conducted a survey of Colorado providers, including time studies of supported employment staff, to capture provider costs. For individual Job Development, the report recommended a 33% increase, and for individual Job Coaching, it recommended a 10% increase. These numbers are a good starting point for recommendations as they reflect the experience of actual providers, rather than theoretical or average costs that go into HCPF's rate methodology. We would like to note that some Alliance members feel that even with rate increases for supported employment settings, provider costs might not be adequately covered, and significant annual rate increases may be necessary to maintain competitiveness. For this reason, it may be prudent to implement a payment model adjustment. We encourage HCPF to consider investing in the HCPF Incentive Pilot as a strategy that could potentially have a positive long-term impact on supported employment services in Colorado.

Day Program

Specialized Habilitation & Supported Community Connections have long been cited by our members as being underfunded. These services struggled a lot during the pandemic and

have been two of the slowest to recover since due to inadequate staffing. A recent Alliance survey found that:

- 45% of respondents (9 out of 20) have waiting lists for Day Habilitation services • 50% (10 out of 20) are providing fewer hours of Day Habilitation than people want/need due to staffing issues

One of the key reasons we believe the rates are inadequate is that they were last rebased around 2008, when the expectations for staffing ratios in these programs were different. In recent years, state and federal expectations and best practices have shifted to emphasize small group and individualized Day supports to make them more meaningful. However, the rate has not been adjusted to compensate for these new expectations. We think significant increases are needed to make these services work the way they are intended. Specifically, when comparing our rates to other states, we would want to know the staffing ratios that the comparison states assume for these services in order to make sure they are truly a good comparison.

Currently, the hourly rate per person for Supported Community Connections is $20.16 for Support Level 3 and $22.60 for Support Level 4 (assuming the majority of individuals served likely fall within these mid-range support levels). For Specialized Habilitation, the rates are $17.08/hour/person for Support Level 3 and $19.48/hour/person for Support Level 4. With an average employee cost of
$31.76, plus the additional facilities, supplies, and equipment costs (vehicles, etc.) associated with Day Habilitation, providers need to utilize staffing ratios averaging 1:4 or 1:5 to make the service viable. By the time staffing ratios reach that size, staff get overwhelmed, and individuals receive services of a poorer quality, which can ultimately lead to safety issues. If staffed at lower (safer) ratios, then you have absences that compound affordability issues; however, if staffed with higher ratios, you risk everyone showing up, have milieu (safety) concerns, and overwhelm staff. Lastly, larger group size is a barrier to community integration. Instead of seamlessly intermingling with the public, larger groups tend to stick out like a tour group, which further isolates them, making the “community” outing counterproductive.

We also want to call attention to Individual Supported Community Connections, which was an option created during the pandemic to allow people to continue to utilize the service (before, the rate only supported groups). While an excellent policy solution, the rate had to be established within existing appropriations, and is too low to make it a realistic option for many people. We had hoped that this service could be utilized more to allow people to explore volunteer opportunities and other activities that might lead to work, but the rate makes it a challenge. We urge the MPRRAC to recommend an increase to align the rate for Individual SCC with a similar service, Community Connector on the CES waiver, which members report is adequate. For comparison, the current rate for Individual SCC is $30.24, and the current rate for Community Connector is $45.96.

Professional Services

Alliance supports the data submitted by Kelly Bianucci in advance of the March 29th MPRRAC meeting related to provider costs for Music, Movement, and Massage Therapies. We were surprised to hear that none of the comparison states HCPF used had data to support a benchmark analysis for Music Therapy. We recommend that HCPF look for additional comparison states. In any case, we urge the MPRRAC to defer to provider experience and cost

data in developing a recommendation for these services, especially in the absence of comparable state data. While the provider pool and number of people accessing these waiver services is relatively small, agencies providing these services to Medicaid members report that they are struggling to stay in business, or are capping the number of Medicaid members they serve due to inadequate rates.

Residential Services

Group Residential Services & Supports
GRSS support between four and eight residents in a home. We applaud HCPF for requesting recent targeted increases to maintain group homes which have been closing at a rapid pace in recent years. Unfortunately, we are still hearing from members that they're struggling to cover the costs of operating these homes. Out of 9 respondents to a recent Alliance survey who currently or previously offered Group Residential services, 5 reported that they have completely discontinued the model for financial reasons, and the remaining 4 have begun or plan to reduce or eliminate their programs.

When examining the numbers, it is clear why. In our survey, we asked members to assume they operated a group home with 6 residents, each at support level 3 (assuming average support needs) and calculate its average annual cost for staffing and overhead. With seven respondents, they averaged such a home would cost $517,842 to operate annually. At a current rate of $235 per day for someone at support level 3 and assuming they reside in the home 360 days per year, the provider would receive $507,600 per year to operate this home.

Individual Residential Services & Supports
Members report that the major pain point with IRSS rates is in settings where 3 people live together in a staffed home, which historically was called the Personal Care Alternative or PCA model. Because these residences typically require a lot of staffing, members report that the rates are insufficient to support these smaller settings. Out of 14 respondents to our survey, 4 reported that they had completely discontinued the PCA model and 9 reported that they have already or plan to reduce the number of people served in PCAs due to the cost and low rates.

Respite

Members have consistently reported struggles with providing respite, a critical service to preventing burnout of caregivers. During the pandemic, Respite received a significant temporary increase to support caregivers, and a number of members reported this was the first time that they didn't lose money on the service. The current hourly Respite rate is $27.28, lower than members' reported average to employ a DSP of $31.76. In our recent survey:

- 80% (12 out of 15 respondents) reported that people are waiting some amount of time to access the service, with the average being between 1-2 months.

Members in rural communities cite travel distance as a major barrier to delivering the service, as the rate does not pay for staff travel time. From 14 survey respondents, 11 reported the average travel distance of 11 or more miles, with 5 reporting that staff travel on average 21-30 miles to deliver the service.

Conclusion

We hope that this information helps to inform the MPRRAC's analysis of HCBS rates. After the June meeting and presentation of more detailed data, Alliance hopes to provide additional information, responses, and recommendations.

Danny Dounglomchunt
Behavioral Health Group

Colorado is falling behind other states on both behavioral health service rates and structure, which is only worsening our existing BH workforce shortage and the lack of access to substance use disorder SUD treatment. As it pertains to MPRRAC's review of Fee-For-Service (FFS) Behavioral Health SUD Services, Behavioral Health Group (BHG) supports either adopting a "bundle" method or adopting the Medicare fee schedule. BHG operates in 22 states plus D.C. and we have seen "fee for service" environments going away across the country. CMS mapped out new G codes designed to pay for OTP services back in 2020, and many states have either adopted those codes or are in process of doing so. Often, states that have not adopted those codes have nevertheless adopted a bundle even if the specific G codes are not adopted yet. The primary benefit of a bundle is that the provider is at risk for utilization rather than the payor. In other words, services are delivered to patients irrespective of whether or not they are highly complex and unstable and need lots of service or less complex and stable for the same bundled rate. Everyone who needs treatment can receive it. This creates incentive for providers to deliver services that are actually needed, rather than billing for additional services solely for the financial incentives. Alternatively, increasing rates to match Medicare would help the behavioral health treatment community immensely. Aside from keeping up with basic inflation, updating to the Medicare fee schedule (or something approximating it) would allow us to scale more rural facilities in part of the state that are demonstrably underserved for these services. Colorado continues to lose providers due to low reimbursement rates, and this is just one way to increase retention.
o By switching to a "bundle" (G code) payment method, OTP providers can deliver multiple services for one set price. For example, rather than billing for multiple codes, a provider could bill a single G code for the following services:
♣ FDA approved MAT medications
♣ Dispensing/administering MAT medications
♣ Substance use counseling
♣ Individual and group therapy
♣ Toxicology testing
♣ Intake activities
♣ Periodic assessment
o Compared to Medicare rates, the Colorado rates are quite low:
♣ Moving to 100 percent of the Medicare fee schedule would get us closer to where we need to be if sticking with a FFS model. The following show where Colorado's rates are currently vs. where we believe they need to be to adequately serve patients while maintaining the SUD workforce:
• Increase admission assessment and re-assessments (H0001) to $159 (currently $109) to match the counselor labor increase since 2022
• Increase Individual counseling (H0004) to $35 (currently $26.05) to match the counselor labor

increase since 2022
• Increase Group counseling (H0005) to $17.00 per 15 minutes (currently $15.59 per 15 minutes) to match the counselor labor increase since 2022
• Treatment plan review (H0006) to $10.00 (currently $8.28) to match the counselor labor increase since 2022

Kelly Bianucci
The Child and Family Center of Denver

I lead one of the largest HCBS professional services provider practices, and last year organized the HCBS professional services community to support HCPF's Time/Cost Study to rationalize rates for this category. We did extensive analysis and reporting, and was ultimately told by HCPF to wait for MPRRAC's review, which is why we're here today (3/29). I'd like to give an overview of our findings and speak to how providers are unable to meet the current needs of the HCBS and IDD patient population due to rates being too low to retain a workforce.

Ellen Jensby

Alliance

I represent most HCBS categories being discussed today and would appreciate the opportunity to respond in each category depending on the discussion of the committee. Alliance also submitted detailed written comments. We hope to have some of our questions answered today live, but have yet to see a detailed explanation for how comparison states were chosen and the characteristics that were used to identify them. We have also not seen a detailed data breakdown of benchmark comparisons by service, and the way services have been bucketed together makes it difficult to understand the impacts of MPRRAC recommendations. We also want to remind the committee that IDD providers rely almost entirely on Medicaid for their revenues and cannot balance impacts of low rates with other payor sources.

Deborah Lively
LeadingAge Colorado

THANK YOU FOR THE OPPORTUNITY TO MAKE COMMENTS. I AM THE DIRECTOR OF PUBLIC POLICY AND PUBLIC AFFAIRS FOR LEADINGAGE COLORADO. WE ARE A STATEWIDE TRADE ASSOCIATION THAT REPRESENTS THE FULL CONTINUUM OF SENIOR LIVING AND AGING SERVICES PROVIDERS, INCLUDING NURSING HOMES, ASSISTED LIVING RESIDENCES, SENIOR HOUSING, ADULT DAY SERVICES AND THE STATE'S PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY OR PACE. WITH THESE COMMENTS, I AM REPRESENTING OUR ASSISTED LIVING AND ADULT DAY SERVICES MEMBERS THAT PARTICIPATE IN MEDICAID.

IN ADDITION TO THE INFORMATION AND DATA PROVIDED BY HCPF, I WANTED TO OFFER YOU SOME ADDITIONAL ITEMS TO CONSIDER AS YOU REVIEW THE MEDICAID RATES FOR ACFS AND ADULT DAY. FIRST, THE COVID PANDEMIC HAD A DISPROPORTIONATE IMPACT ON LONG-TERM

CARE SETTINGS CARING FOR OLDER ADULTS. PROVIDERS ARE STILL RECOVERING FINANCIALLY AFTER SUSTAINING SIGNIFICANT AND COMPOUNDING COST INCREASES DURING THE PANDEMIC. ADULT DAY PROVIDERS HAD TO BASICALLY CLOSE DURING A PART OF 2020 AND WE KNOW SOME OF OUR MEMBERS NEVER REOPENED, ONE IN AN URBAN AREA THAT PRIMARILY SERVED VETERANS.

LABOR, INSURANCE, AND SUPPLY COSTS HAVE CONTINUED TO INCREASE, AND WHILE WE ARE GRATEFUL FOR THE ACROSS THE BOARD AND TARGETED RATE INCREASES TO SUPPORT ENHANCED WAGES FOR DIRECT CARE STAFF, OUR MEMBERS TELL US THAT MEDICAID RATES DO NOT FULLY COVER THEIR COSTS OF PROVIDING CARE.

I ALSO WANT TO MENTION THAT IMPLEMENTATION OF THE FEDERAL HCBS SETTINGS RULE, WHICH REQUIRES THAT INDIVIDUALS ARE SERVED IN A COMMUNITY-INTEGRATED SETTING, HAS PLACED SOME ADDITIONAL PRESSURES ON PROVIDERS, ESPECIALLY SOME ADULT DAY CENTERS. ONE OF OUR MEMBERS CHOSE TO DROP OUT OF THE MEDICAID PROGRAM OVER THE COSTS OF IMPLEMENTING THE RULE.

REGARDING ACCESS, THERE ARE ONLY A FEW ALTERNATIVE CARE FACILITIES THAT TAKE MEDICAID IN THEIR SECURE OR MEMORY CARE UNITS. THIS IS PRIMARILY DUE TO HIGHER CARE COSTS AND STAFFING REQUIREMENTS IMPOSED BY THE DEPARTMENT. WE KNOW HCPF IS CONSIDERING A TIERED RATE STRUCTURE FOR ASSISTED LIVING THAT WOULD BETTER REIMBURSE FOR HIGHER CARE NEEDS AND WE SUPPORT THOSE EFFORTS. INVESTING IN ASSISTED LIVING HELPS DELAY NURSING HOME PLACEMENT, WHICH IS THE MOST EXPENSIVE FORM OF LONG-TERM CARE.

THANK YOU AGAIN FOR THE OPPORTUNITY TO COMMENT. I HOPE THESE POINTS HAVE BEEN HELPFUL TO YOU AS YOU CONSIDER THE ADEQUACY OF MEDICAID RATES FOR ASSISTED LIVING AND ADULT DAY SERVICES.

Ellen Jensby

Alliance

Alliance supports the MPRRAC recommendation to align disparate rates for Personal Care and Basic Homemaker services, which will improve the rate for Basic Homemaker. Because Personal Care on the IDD waivers is already the highest existing rate for that service, IDD providers would not receive an increase. Our members already struggle to sustain Personal Care despite receiving the highest existing rate because of the regulatory requirements.
• Recommendation: In addition to aligning Personal Care rates across waivers to the highest existing rate (T1019), the Outside Denver Personal Care rate should also be increased to the Denver rate of $7.73/unit.
• Policy Recommendation: HCPF and the Colorado Department of Public Health and Environment should find ways to ease the administrative burdens of providing Personal Care to make the rate more sustainable and increase provider participation.

Leslie Mason
Eben Ezer Lutheran Care Center

I plan to share the need for their to be an assisted living memory care Medicaid rate that differs for the normal ACF Medicaid rate. With the staffing ratio being much different in the AL memory care setting but the reimbursement being no different, this is pushing Medicaid recipients that need this level of care into the nursing home setting which results in a higher expense to the Medicaid program than if a more adequate rate was to be reimbursed for the assisted living memory care level of care.

Other Feedback

Keith M. Sterling, MD, FSIR
Peripheral Interventions

Boston Scientific was recently forwarded an email that initiated from Michelle Laplante (see email below) by a physician who sees Varithena, Non-compounded Foam, as an important treatment option for his Colorado Medicaid Patients suffering from Chronic Venous Insufficiency (CVI).

As a Senior Medical Director for Boston Scientific and a physician trained in Vascular and Interventional Radiology, including diagnosis and treatment of venous disease, I appreciate and support your proposal to increase the rates for treatment of Chronic Venous Insufficiency, using Varithena, Non-compounded foam to a level that makes it possible for Colorado physicians to use Varithena in appropriate patients. Below are some facts shared with the Colorado Medicaid Rate Setting Committee regarding Varithena Non-compounded Foam, a non-thermal, non-tumescent ablation treatment for varicose veins.

- Varithena's initial Randomized Controlled Trials, Vanish I and Vanish II led to FDA approval in 20131
- FDA approval was followed by CPT code creation, with the support of multiple medical societies, with CPT codes 36465 & 36466 designated for use when treating CVI with non-compounded foam in truncal veins (AMA CPT Assistant Guidance Attached)
- Last year, Multiple societies released, "The 2023 Society for Vascular Surgery, American Venous Forum, and American Vein and Lymphatic Society Clinical Practice Guidelines for the Management of Varicose Veins of the Lower Extremities. Part II (attached), which included the following recommendation in section 4.2. Thermal vs non-thermal ablation of superficial truncal veins, "we recommend either thermal or non-thermal ablation" for multiple superficial truncal vein indications. Varithena is a non-thermal treatment option for ablation of superficial truncal veins (Guidelines Attached).

The proposed increase in Medicaid rates included in the MPRRAC 2023 Rate Change Track Document (attached), included in the email forwarded to us and posted on the posted on the CO Department of Health Care website under the 2023 report section, shows a very low current payment rate that does not cover the cost of the procedure. The proposed payment

rates place payment closer to Colorado and surrounding states' Medicare rates as well as surrounding state Medicaid rates and are in line with the costs of the procedure.

The previous rates were far below covering the cost of the treatment represented by these CPT codes thus, even though treatment was supported by clinical evidence, (please see attached Bibliography) and society guidelines, and all Medicare patients can receive this treatment when medically appropriate per all MAC varicose vein LCDs and LCAs2 including Colorado Medicare patients, Colorado Medicaid patients are not able to benefit from this treatment, which in some cases, is the only treatment available for these patients due to their anatomy or failure of previous CVI treatments or concern for thermal damage related to treatment with Radio Frequency Ablation or Laser Ablation.

Also, the proposed payment rates place Colorado Medicaid Rates for treatment with Varithena, Non-compounded Foam (36465 & 36466) near rates for Radio Frequency Ablation or Laser Ablation and thus do not represent a significant financial burden on the Colorado Medicaid Program while affording physicians treating Colorado Medicaid patients an additional tool to be used when, in their clinical judgment, Varithena is the most appropriate treatment for their patients suffering from CVI symptoms that compromise their activities of daily living.

Please reach out if you need additional information or support regarding the use of Varithena to treat CVI in appropriate, symptomatic patients, to help with the adoption of your proposed rates.

References

1. FDA Approved Indication: Treatment of incompetent great saphenous veins (GSV), accessory saphenous veins, and visible varicosities of the GSV system above and below the knee. The treatment plan proposed will not be employed as cosmetic procedure, but rather will be used to displace the symptomatic veins and thus, treat this disease process. Initial U.S. FDA Approval: Nov 2013. To access the Varithena™ approval document, visit the FDA website at: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2013/205098Orig1s000Approv.pdf
2. Centers for Medicare & Medicaid Services – Medicare Coverage Database Search – Search Term Varicose MCD Search Results (cms.gov)

Mel Persion

I am writing to support the future of ABA therapy services in Colorado.
Please consider emergency funding and increased reimbursement rates for ABA therapy before more centers close down.

My daughter has severe/profound autism. Not the hip and trendy kind that everybody is self-diagnosing with.

Without ABA, my daughter would have continued to be a stimming, aggressing, self-harming mess, peeing and pooping herself in a corner for the rest of her life. ABA has given her a life. I call ABA therapist miracle workers and midwives of rebirth.

Thanks to daily ABA therapies since she was 2 years old, my daughter is potty-trained, can read, write, type, carry on simple conversations to tell us what she wants, and take care of her daily self care needs like feeding herself, and brushing her hair and teeth. Her behavior has improved immensely also.

All occupational therapists and physical therapists dropped us because they were not trained in ABA and did not know how to hold my daughter's attention. The only reason that the speech therapist did not drop us is because she was also our Board Certified ABA therapist and knew how to reach our daughter.

School has also been a joke. With the inclusion movement, she is placed in general education classes beyond her understanding, with an aide to keep her quiet the whole time. She is bored out of her mind at school, does not learn anything there, and she hates school.

ABA keeps up on children's current motivators and reinforcers to keep them interested in learning. Our children are not motivated by social acceptance or grades. Currently, my daughter's reinforcers are laminated pictures of her favorite animated characters. To earn more characters, she learns more and more skills. She is currently able to read a picture book and summarize what she read and answer questions about it.

Please do not buy into the conspiracy theories of the self-diagnosed masses. I dare you to ask any person who says ABA is bad, if they have ever attended an ABA session in person. I dare you. You will find that they haven't. They are merely parrots of other online parrots. They tell each other on social media how to complete doctors' questionnaires just so in order to get a diagnosis so that they can "come out as autistic" on social media.

My daughter loves going to ABA. She prepares jokes and pranks for her ABA therapists every day. She is able to relay to me how her pranks went every day. On weekends, she asks to go to ABA and says she misses her ABA therapists. She is 15 years old now and still insists on going. Seeing the progress she makes, we are happy to have her keep attending ABA every day.

Even if years later, after her Dad and I are dead, she is living in a residential care place, she will be less of a burden on those caregivers because of all that ABA has taught her. And if she is abused, she will be able to tell someone that she is being abused. Our goal is for her to have gainful employment, even if it is being a greeter in a store. She would be so proud to have a job and be a productive member of society.
The self-diagnosed folks are doing everything they can to erase our children, to say that children like ours who are severely/profoundly affected by autism do not exist, that autism is a gift and does not need any therapies, that all therapies should be de-funded. Please do not believe their lies.

On the way to work one day, I heard that a listener called a radio host and said she feels left out because all her friends are claiming to have autism. These people have hijacked a legitimate diagnosis and made a clown show out of it. Since the word autism doesn't even mean anything anymore with everybody claiming to have it, we have resorted to adding the words severe and profound before our kids' autism diagnosis. These self-diagnosed loudmouths are quick to say that levels don't exist and that they all have problems. All while they have decent jobs with great pay, spouses and partners, and even children. They even have gone to comical lengths to go mute at times in order to call themselves nonverbal. When people

remind them that they are not nonverbal at all, they say, "Well, I am non-speaking because of my autism" It is ridiculous.

These people have taken over everywhere, not just social media, but even autism societies all over the country, all in an effort to claim themselves autistic and to erase therapies for our children. They have taken advantage of the fact that we, the parents of children who truly have classic autism, are too busy to counteract their attacks and harassment of us. They have told us we can't speak for our kids because we don't have autism. Who speaks for our kids then, if not us?

We discuss these things, without being harassed by them, in our groups such as "National Council on Severe Autism", "Support Group for Parents of Severely Autistic Children with LD" (LD being learning disabled), and "Parents & Primary Caregivers of Children with Severe/Classic Autism".

Please don't leave behind the most vulnerable populations. Our children need ABA therapies in order to communicate and to live. Please don't deprive them of this basic need.

Patrick Knipe
UCHealth

I hope this email finds you well.

My name is Patrick Knipe and I am Vice President of Payer Strategy and Managed Care Contract at UCHealth, which includes **University of Colorado Hospital**.

I am writing to request a meeting with HCPF to discuss a matter of great importance and urgency related to the reimbursement methodology for organ transplant costs under the Colorado Medicaid Fee Schedule.

As you may be aware, the current Health First Colorado reimbursement methodology approach does not adequately cover the expenses associated with organ transplants, particularly the organ acquisition expenses for which there is no reimbursement. This places a significant financial strain on University of Colorado Hospital.

Section 10 CCR 2505-10-8.221 of the Colorado Code of Regulations provides HCPF with the discretion to enter into contractual arrangements with selected providers under a negotiated global arrangement, including acquisition costs. We believe that exploring this option could present a mutually beneficial opportunity to ensure that organ transplant costs are more comprehensively covered, thereby enhancing the quality of care and access for Medicaid beneficiaries in Colorado.

Our organization is deeply committed to delivering high-quality healthcare services, including organ transplants, to our community. We are eager to engage in discussions with HCPF to explore how we can collaborate to develop a contractual arrangement that aligns with the needs of all stakeholders, especially the patients we serve.

I kindly request the opportunity to meet with you at your earliest convenience to further discuss this matter.

Please let me know a time that would be convenient for you to discuss this further, as well as if there are other contacts at HCPF with whom we should discuss this request.

Thank you for considering this request. We look forward to the possibility of working together towards a solution that enhances healthcare outcomes for Coloradans receiving Medicaid.
