



COLORADO

Department of Health Care
Policy & Financing

2025 Medicaid Provider Rate Review Analysis and Recommendation Report

November 1, 2025

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

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Executive Summary

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

Benchmark Ratio and Anticipated Fiscal Impact by Service Category					
Service Category	CO as a Percent of the Benchmark	MPRRAC Recommendations - Fiscal Impact		HCPF Recommendations - Fiscal Impact	
		Total Funds	General Fund	Total Funds	General Fund
Dialysis and Dialysis-related Services - FACILITY	81.02%	\$103,994	\$28,515	\$103,994	\$28,515
Dialysis and Dialysis-related Services - NON- FACILITY	85.49%	\$2,588	\$710	\$2,588	\$710
Dental for People with Intellectual and Developmental Disabilities (DIDD)	131.00%	\$1,073,485	\$207,934	-\$51,223	-\$9,922
Durable Medical Equipment	91.71%	\$1,039,849	\$285,127	-\$1,434,889	-\$393,447
Prosthetics, Orthotics and Disposable Supplies - PROSTHETICS	74.07%	\$564,395	\$154,757	\$0	\$0
Prosthetics, Orthotics and Disposable Supplies - ORTHOTICS	82.66%	\$1,067,224	\$292,633	-\$222,925	-\$61,126
Prosthetics, Orthotics and Disposable Supplies - ENTERAL FORMULA	141.52%	\$0	\$0	\$0	\$0
Prosthetics, Orthotics and Disposable Supplies - OTHER AND DISPOSABLE SUPPLIES	95.74%	\$2,894,413	\$793,648	\$0	\$0
Laboratory and Pathology Services	93.34%	\$0	\$0	\$0	\$0
Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy - PHYSICAL THERAPY	100.85%	\$363,088	\$181,544	-\$889,235	-\$444,618

Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy - OCCUPATIONAL THERAPY	96.57%	\$1,150,651	\$575,326	\$257,450	\$128,725
Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy - SPEECH THERAPY	93.63%	\$1,950,074	\$975,037	\$458,191	\$229,096
Specialty Care Services	81.09%	\$295	\$81	\$295	\$81
Early Intervention TCM	73.56%	\$660,902	330,451	\$0	\$0
Targeted Case Management - CASE MANAGEMENT	91.48% ¹	\$5,144,620	\$2,572,310	\$0	\$0
Targeted Case Management - TRANSITION COORDINATION	122.54%	\$0	\$0	\$0	\$0
Vision Services	81.12%	\$3,268,733	\$896,287	\$380,327	\$104,286
Physician Services - ALLERGY AND IMMUNOLOGY	90.03%	\$21,470	\$5,887	\$21,470	\$5,887
Physician Services - CARDIOLOGY	95.03%	\$194,302	\$53,278	-\$90,119	-\$24,711
Physician Services - DERMATOLOGY	76.73%	\$65,597	\$17,987	\$65,597	\$17,987
Physician Services - ED AND HOSPITAL E&M	90.88%	\$278,538	\$76,375	-\$1,203,838	-\$330,092
Physician Services - ENT	86.77%	\$79,398	\$21,771	\$2,538	\$696
Physician Services - FAMILY PLANNING	113.86%	\$229,334	\$62,884	-\$1,143,742	-\$313,614
Physician Services - GASTROENTEROLOGY	91.21%	\$174	\$48	\$174	\$48
Physician Services -GYNECOLOGY	83.32%	\$98	\$27	\$65	\$18
Physician Services - HEALTH EDUCATION	85.31%	\$1,409	\$386	\$0	\$0
Physician Services - MEDICATION INJECTIONS AND INFUSIONS	112.84%	-\$34,143	-\$9,362	-\$34,143	-\$9,362
Physician Services - NEURO/ PSYCHOLOGICAL TESTING SERVICES	122.21%	\$3,818,091	\$1,046,921	-\$1,553,220	-\$425,893

¹ Due to the targeted rate increase for T2023+HI, which is the TCM monthly rate, the MPRRAC requested that the benchmark ratio and fiscal impact numbers be updated to reflect this rate.

Physician Services - NEUROLOGY	93.91%	\$113,980	\$31,253	-\$135,536	-\$37,164
Physician Services - PRIMARY CARE AND EVALUATION AND E&M	87.26%	\$969,652	\$265,879	-\$2,594,476	-\$711,405
Physician Services - RADIOLOGY	98.29%	\$211,008	\$57,859	\$211,005	\$57,858
Physician Services - RESPIRATORY	103.00%	-\$30,130	-\$8,262	-\$30,130	-\$8,262
Physician Services - SLEEP STUDY	123.65%	-\$259,414	-\$71,131	-\$259,414	-\$71,131
Physician Services - VACCINES AND IMMUNIZATIONS	95.12%	\$342,172	\$93,823	-\$169,896	-\$46,585
Physician Services - VASCULAR	99.61%	\$279	\$76	\$279	\$76
Total		\$26,286,126	\$8,940,059	-\$8,308,813	-\$2,313,349

Summary of rate benchmark comparison results and anticipated fiscal impacts by service category

Using the recommendations from the MPRRAC process, the Department of Health Care Policy and Financing (HCPF) staff prepare recommendations in accordance with anticipated budget restrictions for the coming fiscal year, Medicaid trends, and HCPF's budget challenges. HCPF seriously considers the MPRRAC's recommendations when prioritizing HCPF recommendations; however, the budget allowance may not allow HCPF and MPRRAC recommendations to align.

The total anticipated fiscal impact of the MPRRAC's recommendations is estimated to be \$26,286,126 total funds, including \$8,940,059 General Fund.

The total anticipated fiscal impact of HCPF's recommendations is estimated to be -\$8,308,813 total funds, including -\$2,313,349 General Fund.

Introduction

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

In 2015, the Colorado General Assembly adopted Senate Bill 15-228, "Medicaid Provider Rate Review," and it was amended by Senate Bill 22-236 in 2022, an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes), HCPF established a rate review process that involves three components:

- assess and, if needed, review a three-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review;
- provide recommendations on all rates reviewed and present them in a report published the first of every November.

The Rate Review Process is advised by the MPRRAC, whose members recommend changes to the three-year schedule, provide input on reports published by HCPF, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year Three of the first three-year rate review cycle, began in March 2025 and included a general discussion of services under review and stakeholder feedback. Summaries from meetings, including presentation materials, meeting minutes, meeting schedule, previous reports, and more can be found on the HCPF [website](#). Members of the public are encouraged to participate in the Rate Review Process; provide insight on access, quality, and provider rates; and attend meetings. Public stakeholders are invited to provide comments during the meetings on the services they represent.

This report contains:

- comparisons of Colorado Medicaid provider rates to those of other payers;
- access to care analyses; and
- assessments of whether payments were sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services, including where additional research is necessary to identify potential access issues.

Payment Philosophy

The Rate Review Process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process, which includes feedback from the MPRRAC, has helped inform HCPF's payment philosophy for fee-for-service (FFS) rates.

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

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

When Medicare is not an appropriate comparator, HCPF may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While HCPF has historically viewed payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below must be considered when setting or changing a rate. These include:

- budget constraints that may prevent payment at a certain amount;
- investigating whether a rate change could have disproportionately negative impacts for individual providers;
- identifying certain services where HCPF may want to adjust rates to incentivize utilization of high value services; and
- developing systems to ensure that payments are associated with high-quality provision of services.

When the Rate Review Process indicates a current rate does not align with HCPF's payment philosophy, HCPF may recommend or implement a rate change. It is also important to note that HCPF may or may not recommend a change, due to the considerations listed above.

Format of Report

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

Service Description

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

- Total Adjusted Expenditures - SFY 2023-24.
- Total Members Utilizing Services - SFY 2023-24.
- Year-over-year Change in Members Utilizing Services - SFY 2023-24 - SFY 2022-23
- Total Active Providers - SFY 2023-24.
- Year-over-year Change in Active Providers - SFY 2023-24 - SFY 2022-23

Rate Comparison Analysis

HCPF contracted with the actuarial firm, CBIZ Optumas, to assist in the comparison of Colorado Medicaid provider rates to those of other payers. The resulting rate comparison analysis outlined in this section provides a reference point for how Colorado Medicaid reimbursement rates compare to other payers.

Analysis in this section is based on SFY 2023-24 administrative claims data and contains a rate benchmark comparison, which describes (as a percentage) how Colorado Medicaid payments compare to other payers. This section also lists the number of procedure codes compared to either Medicare or an average of other states' Medicaid rates, and the range of individual rate ratios.

HCPF first examined whether a service had a corresponding Medicare rate to identify comparator rates for analysis. Medicare rates were primarily relied upon for this analysis when available and appropriate. When Medicare rates were unavailable, HCPF relied upon other state Medicaid agency rates when the benchmark states have applicable fee-for-service rates for the service category. HCPF utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates;
- Medicare's rates, methodologies, and service definitions are generally available to the public;
- Medicare's rates are typically updated on a periodic basis; and
- Most services covered by Colorado Medicaid are also covered by the Medicare program.

Access to Care Analysis

In evaluating access to care, HCPF utilized up to eight metrics for each service category. However, some service categories did not utilize all eight metrics depending on the applicability of each measure. Three of these metrics, provider participation, per utilizer per year/month (PUPY/PUPM) expenditure, and per utilizer per year/month (PUPY/PUPM) utilization, were obtained through HCPF's contract with the Center for Improving Value in Health Care (CIVHC) to assist in evaluating access. HCPF also conducted an internal access to care analysis measuring panel size, penetration rate, special providers, drive times, and telemedicine accessibility. For the purposes of this current report, the current access to care metrics do not fully capture how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurances, or to the uninsured population.

Stakeholder Feedback

Refer to Appendix I for stakeholder feedback, which was collected from October 2024 through October 1, 2025. Stakeholders are encouraged to sign up to make a public comment during the quarterly MPRRAC meetings, as well as send in their feedback on their service(s) via email. Throughout the rate review cycle, HCPF sends the MPRRAC any stakeholder feedback that has been received so they are kept abreast of the needs of providers. The MPRRAC considers all stakeholder feedback, from public meetings and sent in via email, to inform the recommendations they make. Feedback in Appendix I is verbatim and unaltered from public stakeholders.

Additional Research

For certain service groupings and regions, particularly when HCPF's analysis indicated a potential access issue, HCPF worked to identify other data sources to conduct

additional research during the MPRRAC process. Some of these data sources were created and maintained as part of HCPF's ongoing benefit management and programmatic operations, while others were created by other organizations or State agencies. HCPF utilized these data sources to conduct further research for the 2025 Medicaid Provider Rate Review Analysis Report. Additional research included:

- Examining claims and enrollment data to understand if members are accessing services in settings, or via delivery systems, that are excluded from the rate review analysis.
- Reviewing relevant, regional results on Key Performance Indicators (KPIs), which are tracked as a part of Colorado Medicaid's delivery system, the Accountable Care Collaborative.
- Reviewing relevant, practice-level results on quality metrics, including Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures.
- Working with HCPF's provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.
- Seeking information from the State Health Care Workforce Work team to determine the general impact of health care workforce burnout, inflation, and health care workforce shortages to understand how Medicaid reimbursement rates might have to be adjusted due to these post-COVID19 induced factors.
- Examining regional and statewide reports and studies published by other agencies, such as the Kaiser Family Foundation (KFF), the Home Care and Hospice Association of Colorado (HHAC), Menges Group, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Recommendations

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

The report includes recommendations from HCPF. The November 1, 2025 budget proposes rate decreases for some services. The proposed budget is not discussed in

this report. Information related to proposed reductions can be found in HCPF's Legislator Resource Center² and complete information on the proposed budget is located on the website for the Office of State Planning and Budgeting.³

Limitations

Results from this report, emerging macro and micro environmental factors (i.e., inflation, health care workforce burnout, and health care workforce shortages) and additional research informed the development of HCPF recommendations. Still, it is important to note limitations inherent to analyses in this report and limitations that exist generally when evaluating payment sufficiency and access to care.

The access to care analyses and resulting conclusions are based on administrative claims data. Claims-based analyses do not provide information regarding appointment wait times, quality of care, or differences in provider availability and service utilization based on insurance type; nor do claims-based analyses allow for HCPF to quantify care that an individual may have needed but did not receive nor the provider enrollment versus providers seeing Medicaid patients. In addition, data analyses use active providers, which includes any billing or rendering provider with at least one Colorado Medicaid paid claim in a given month between July 2023 - June 2024. When HCPF evaluates other data sources, there may be assumptions and extrapolations made due to differences in geographic area designations, differences in population definitions, and differences in service definitions. Additionally, many of the access to care indicators are relative, and without defined standards, cannot indicate if all regions are performing well or if all regions are performing poorly. However, these indicators, when analyzed all together, can help identify regions for focus.

There are complicating factors regarding determining rate sufficiency. Member access and provider retention are influenced by factors beyond rates, such as: provider outreach and recruitment strategies; the administrative burden of program participation; health literacy and healthcare system navigation ability; provider scheduling and operational practices; and member characteristics and behaviors. Additionally, rates may not be at their optimal level, even when there is no indication of member access or provider retention issues. For example, rates that are above optimal may lead to decreases in the provision of high-quality care or increases in the provision of services in a less cost-effective setting.

² <http://colorado.gov/hcpf/legislator-resource-center>

³ <https://www.colorado.gov/governor/office-state-planning-budgeting>

2025 Tariff Survey

In May 2025, the Rates Review and Research Team received feedback from providers on the potential impact of federal tariffs on costs and the ability to provide services to Medicaid. To better understand provider experience, a short survey was sent to Colorado Medicaid providers.

In the survey, providers were asked if they received communication from suppliers regarding increased prices or reduced services. Visual data on the survey, potential flaws of the survey, and the raw data of the survey respondents is provided in Appendix G.

Dialysis and Dialysis-related Services - Overview

Service Description

Dialysis and dialysis-related services provide life-sustaining treatment for individuals with kidney failure or end-stage renal disease (ESRD). These services involve the use of specialized equipment to filter waste products and excess fluid from the blood when the kidneys cannot. These also include non-routine services.

Dialysis and Dialysis-related Services: Facility vs Non-Facility	
Facility	Non-Facility
Routine Services	Non-Routine Services
Services bundled into a composite rate	Services reimbursed through a professional claim according to the FFS rate per procedure code
Composite rate is determined according to the county where the facility is located	Services are separate from the bundled facility services

Table 1. Dialysis and dialysis-related services subcategory comparison.

Dialysis and Dialysis-related Services - Facility

Service Description

Dialysis and dialysis-related services - facility services provide treatment in state-approved freestanding dialysis treatment centers and home settings. Facility dialysis providers receive a composite rate for a variety of treatments based on the county where the facility is located.

Dialysis and Dialysis-related Services - Facility Statistics	
Total Adjusted Expenditures SFY 2023-24	\$10,904,568
Total Members Utilizing Services in SFY 2023-24	600
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-4.91%
Total Active Providers SFY 2023-24	80
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-3.61%

Table 2. Dialysis and dialysis-related services - facility total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The [July 2024 Health First Colorado dialysis fee schedule](#) assigns composite rates for dialysis services by geographic region and prescribes which counties are categorized into the different regions. In addition, the July 2024 Health First Colorado dialysis fee schedule assigns composite rates for in-home continuous cyclic peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) services by geographic region. Each rate, which is based on the county where the service was performed and whether the service was categorized as in-home CCPD and CAPD, was applied to the paid units for these services to obtain the Colorado repriced amount.

Dialysis and dialysis-related services - facility rates were compared to Medicare. The Medicare repriced amount was calculated by applying [Medicare's 2024 Prospective Payment System \(PPS\)](#). The process to determine the Medicare repriced amount is as follows:

1. The 2024 Medicare PPS base rate was \$271.02.
2. The base rate was adjusted by a cost-of-labor factor, based on the following:
 - a. Local hospital wage index
 - b. Whether the facility was located in a rural area
3. Next, adjustments based on patient characteristics were applied.
 - a. Age
 - b. Comorbidities
 - c. Data for some patient characteristics were unavailable.
 - i. Body mass index
 - ii. Body surface area
 - iii. Dialysis onset
 - d. Data on low-volume facilities and high-cost outliers were unavailable.
4. Next, adjustments were applied for the training add-on.

5. Finally, the following adjustments were not applied due to a lack of data.
 - a. Transitional Drug Add-on Payment Adjustment (TDAPA)
 - b. Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)

For more information on this methodology, see Appendix E.

On average, Colorado Medicaid payments for dialysis and dialysis-related services - facility are estimated to be at 81.02% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Dialysis and Dialysis-related Services - Facility Repriced Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Overall Repriced Benchmark Ratio
\$10,904,568	\$13,459,656	81.02%

Table 3. Comparison of Colorado Medicaid dialysis and dialysis-related services - facility service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$2,555,088 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. There are 8 assigned rate areas, and each rate area has an additional rate for In-Home CCPD and CCPD services, for a total of 16 reviewed rate types. All 16 rate types analyzed in this service grouping were compared to Medicare, and one rate type did not have valid utilization data during SFY 2023-24 so a rate-only comparison was performed. Individual rate ratios for dialysis and dialysis-related services - facility were 75.83%-90.46%.

Access to Care Analysis

As seen in the dialysis and dialysis-related services - facility panel size visual (Appendix B, Figure 1), the average number of utilizers per provider remained stable in urban and rural areas. The in-home services analyses (Appendix B, Figures 4 & 5) show that the percentage of individual members that utilized in-home services increased, while the percentage of total visits that were delivered in members' homes decreased. The drive time analysis (Appendix B, Figure 6) shows that parts of Eastern and Western Colorado had relatively high drive times (over an hour). These findings suggest that access to care is stable, although longer distances may impact accessibility.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

During the March meeting, stakeholders from DaVita communicated their benchmark results, which deviated from the benchmark results obtained by HCPF and CBIZ Optumas. After the meeting, HCPF communicated with DaVita via email to investigate these differences. The following table shows how HCPF's and DaVita's estimated Medicare rates for the Colorado Springs rate region differ.

Colorado Springs Medicare Rate Estimation					
	Base Rate	Wage-Adjusted Rate	PPS Adjustment Factors	Average Medicare Rate (Benchmark)	PPS Adjustment Factor Assumptions
HCPF	\$271.02	\$263.96	+\$3.28	\$267.24	Based on FY 2023-24 Colorado Springs Medicaid claims data. (Member age and comorbidities based on diagnosis codes.)
DaVita	\$271.02	\$263.96	+\$16.51	\$280.47	Based on DaVita's FY 2023-24 national average.

Table 4. A comparison of HCPF's and DaVita's average estimated Medicare benchmarks for the Colorado Springs rate area.

As seen in Table 4, the difference in the estimated Medicare rates arises from differences in the estimated PPS adjustment factors. Since HCPF estimated PPS adjustment factors are based on member data and DaVita's estimated PPS adjustment factors are based on DaVita's nation-wide averages from their FY 2023-24 data, HCPF and CBIZ Optumas agree that HCPF's estimated Medicare rates are accurate and appropriate benchmarks. Please see Appendix A2 for more details.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for dialysis and dialysis-related services - facility.

Dialysis and Dialysis-related Services - Facility Top 10 Assigned Rate Areas by Utilization					
Rank	Assigned Rate Area	In-Home CAPD and CCPD	Benchmark Ratio	Utilization	% of Total Utilization
1	Denver, Aurora, Lakewood		81.47%	26,751	46.02%
2	Denver, Aurora, Lakewood	In-Home	81.74%	8,166	14.05%
3	Colorado Springs, CO		77.49%	5,098	8.77%

4	Rural Colorado		76.28%	3,258	5.61%
5	Colorado Springs, CO	In-Home	77.80%	3,128	5.38%
6	Pueblo, CO		77.24%	2,904	5.00%
7	Boulder, CO		90.46%	1,956	3.37%
8	Greeley, CO		84.78%	1,555	2.68%
9	Fort Collins, CO	In-Home	82.29%	1,225	2.11%
10	Fort Collins, CO		89.64%	1,177	2.02%

Table 5. Top 10 rate types by utilization

MPRRAC Recommendations

- For dialysis and dialysis-related services - facility, where the rates are based on the rate area, the MPRRAC recommends increasing the rates that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$103,994 total funds, including \$28,515 General Fund.

HCPF Recommendations

- For dialysis and dialysis-related services - facility, where the rates are based on the rate area, HCPF recommends increasing the rates that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$103,994 total funds, including \$28,515 General Fund.

Dialysis and Dialysis-related Services - Non-Facility

Service Description

Dialysis and dialysis-related services - non-facility provide non-routine life-sustaining treatment for patients with kidney failure or End-Stage Renal Disease (ESRD). This service allows patients to receive non-routine dialysis services. Non-facility dialysis providers are reimbursed based on specific treatment provided to the patients.

Dialysis and Dialysis-related Services - Non-Facility Statistics	
Total Adjusted Expenditures SFY 2023-24	\$1,359,519
Total Members Utilizing Services in SFY 2023-24	826
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-8.39%
Total Active Providers SFY 2023-24	171
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	1.18%

Table 6. Dialysis and dialysis-related services - non-facility total expenditure and utilization data (SFY 2023-24).

Benchmark Rationale

The rates for dialysis and dialysis-related services - non-facility were compared to Medicare and the rates from 8 benchmark states: Arizona, California, Michigan, Minnesota, Nebraska, Nevada, Oklahoma and Oregon. These states were chosen as benchmarks for the rate comparison analysis because they have comparable dialysis benefit packages and covered populations to Colorado. Additionally, most of the benchmark states are geographically close to Colorado and share provider operating groups and networks.

Rate Comparison Analysis

The dialysis and dialysis-related services - non-facility service grouping has 28 procedure codes. The rates for 23 codes (82.14%) were compared to Medicare, while the rates for 5 codes (17.86%) were compared to rates from benchmark states. When comparing procedure code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definitions. This leads to inconsistencies in the number of benchmark states available for different codes:

Dialysis and Dialysis-related Services - Non-Facility Benchmark States	
Procedure Code	Benchmark States
90940	California, Minnesota, and Nevada
90952, 90953	Michigan, Minnesota, Nebraska, Nevada, Oklahoma, and Oregon
90989	Arizona, California, Michigan, Minnesota, Nevada, and Oregon
90993	Arizona, California, Michigan, Minnesota, and Nevada

Table 7. Dialysis and dialysis-related services - non-facility benchmark states (SFY 2023-24).

Among these 28 codes, 7 codes (25%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for dialysis and dialysis-related services - non-facility were 68.86%-445.98%. While the range for this service is large, there were no benchmark outliers with utilization. Moreover, 99% of the utilization in this category was for codes with benchmark ratios between 80% and 100%.

On average, Colorado Medicaid payments for dialysis and dialysis-related services - non-facility are estimated to be at 85.45% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Dialysis and Dialysis-related Services - Non-Facility Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 8 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$1,359,519	\$1,590,196	85.49%

Table 8. Comparison of Colorado Medicaid dialysis and dialysis-related services non-facility service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$230,677 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the dialysis and dialysis-related services - non-facility panel size visual (Appendix B, Figure 7), the average number of utilizers per provider remained stable in urban and rural regions. The special providers visual (Appendix B, Figure 10) shows that the percent of active providers that serve only one Medicaid member remained stable. The drive time analysis (Appendix B, Figure 11) shows that much of the state had high drive times (over an hour). These findings suggest that longer distances may impact accessibility.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for dialysis and dialysis-related services - non-facility.

Dialysis and Dialysis-related Services - Non-Facility Top 10 Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	90935	HEMODIALYSIS ONE EVALUATION	99.55%	2,533	24.76%
2	90970	ESRD SVC PR DAY PT 20+	82.08%	2304	22.52%
3	90960	ESRD SRV 4 VISITS P MO 20+	83.60%	2,131	20.83%
4	90945	DIALYSIS ONE EVALUATION	83.43%	1168	11.42%
5	90961	ESRD SRV 2-3 VSTS P MO 20+	83.72%	1,013	9.90%
6	90966	ESRD HOME PT SERV P MO 20+	83.60%	495	4.84%
7	90962	ESRD SERV 1 VISIT P MO 20+	83.38%	189	1.85%
8	90947	DIALYSIS REPEATED EVAL	94.56%	124	1.21%
9	90969	ESRD SVC PR DAY PT 12-19	85.18%	93	0.91%
10	90937	HEMODIALYSIS REPEATED EVAL	112.89%	46	0.45%

Table 9. Dialysis and dialysis-related services - non-facility top 10 procedure codes by utilization.

MPRRAC Recommendations

- For dialysis and dialysis-related services - non-facility, the MPRRAC recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes that are above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$2,588 total funds, including \$710 General Fund.

HCPF Recommendations

- For dialysis and dialysis-related services - non-facility, HCPF recommends increasing the rates for all codes that are under 80% of the benchmark ratio to

80% of the benchmark and to keep the rates for all codes that are above 80% of the benchmark the same.

- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$2,588 total funds, including \$710 General Fund.

Dental for People with Intellectual and Developmental Disabilities (IDD)

Service Description

DIDD services is an enhanced dental program for Colorado Medicaid members aged 21 and older who are enrolled in the Home and Community-Based Services (HCBS) Developmental Disabilities (DD) or Supported Living Services (SLS) waivers programs. This dental program recognizes the unique dental challenges faced by these individuals, providing supplementary reimbursement to providers who deliver comprehensive dental care. By offering additional support, dental IDD Services aim to improve oral health outcomes for a population with complex medical and personal care needs.

Health First Colorado contracts with an Administrative Services Organization (ASO) to provide dental coverage for its members. Following a competitive RFP process, DentaQuest was awarded the contract in 2024 to provide services for another 5 years. DentaQuest is responsible for authorizing dental services, processing claims, and developing the provider network, among other responsibilities. DentaQuest began claims administration for the IDD Waiver Programs on July 1, 2015.

For this report, DentaQuest provided DIDD claim data for SFY 2021-22, SFY 2022-23, and SFY 2023-24. Since the SFY 2023-24 data only includes the first eight months, we projected the full year by examining how claims typically trend. Specifically, we compared the first eight months to the full year for SFY 2021-22 and SFY 2022-23 and calculated the average ratio. This average was then applied to the SFY 2023-24 eight-month data to estimate the full 12-month totals. All figures presented in this report for SFY 2023-24 will reflect these projected full-year estimates unless otherwise noted.

A summary of the statistics for DIDD services is provided below:

DIDD Statistics	
Total Adjusted Expenditures SFY 2023-24 (8-month)	\$3,452,312
Total Adjusted Expenditures SFY 2023-24 (12-month)	\$5,075,033
Total Members Utilizing Services in SFY 2023-24	5,296
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-7.34%
Total Active Providers SFY 2023-24	918
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	8.30%

Table 10. DIDD total expenditure and utilization data (SFY 2023-24)

Benchmark Rationale

The American Dental Association (ADA) survey data provides national commercial average dental fees for over 200 commonly used dental procedure codes. We typically rely on ADA survey data as the benchmark for setting Colorado Medicaid dental IDD rates. However, recent changes have limited access to this data. According to the ADA⁴, “The ADA cannot quote fees for dental procedures and is forbidden by federal law to set or recommend fees. The Council on Dental Practice elected to discontinue the Survey of Dental Fees in 2023 and it has been removed for download, due to a change in law eliminating safe harbor disclosure. Posting such information, therefore, is now legally problematic.”

To ensure legal compliance and promote transparency, three alternative benchmarking strategies were employed. The first relied on the regular Colorado Medicaid dental State Plan, as recommended by the MPRRAC committee. The second utilized the 2022 ADA survey data, with appropriate trend adjustments, to project 2025 rates. The third drew upon benchmarks from other states with established enhanced Medicaid dental programs for individuals with intellectual and developmental disabilities (IDD).

Rate Comparison Analysis

Regular Colorado (CO) Medicaid Dental State Plan

HCPF analyzed the difference between dental IDD rates and regular Medicaid dental rates in the State Plan to assess rate alignment and equity. This comparison helps identify any discrepancies that may affect provider participation or access to care for individuals with IDD.

Category	Number of Codes	Percent
Rate Higher Than CO Medicaid Dental Rate	181	40.77%
Rate Lower Than CO Medicaid Dental Rate	15	3.38%
Rate Not Found in CO Medicaid Dental	221	49.77%
Excluded Codes ⁵	27	6.08%

Table 11. DIDD Medicaid dental comparison analysis

⁴ Please refer to the ADA website for more details:

<https://www.ada.org/resources/research/health-policy-institute/dental-care-market>

⁵ Three DIDD codes were excluded due to having a reimbursement rate of \$0. Twenty-four DIDD codes were excluded due to being manually priced.

This analysis result listed above suggested that dental IDD services are prioritized with higher reimbursement and more coverage but there is an opportunity to evaluate the 3.38% of the codes reimbursed at lower rates. These codes could represent potential inconsistencies or undervaluation of certain procedures within the dental IDD service context. In addition, the 49.77% of dental IDD service codes not covered under regular Colorado Medicaid dental services indicate that there may be a need for benefit alignment and evaluation.

Among the 196 comparable dental IDD procedure codes covered by the State Plan, 89 of them (45.41%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate-only ratios for these 196 DIDD codes were 70.39% - 346.12%.

On average, Colorado Medicaid payments for these 196 dentalIDD codes are estimated at 131.00% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DIDD Repriced Benchmark Comparison		
Colorado Repriced	Regular CO Medicaid State Plan Repriced	Overall Repriced Benchmark Ratio
\$5,075,033	\$3,874,071	131.00%

Table 12. Comparison of Colorado Medicaid DIDD service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$1,200,962 total funds if Colorado had reimbursed at 100% of the benchmark for the eight months of available data in SFY 2023-24.

Projected ADA 2025 Rate

The projected ADA rates for 2025 were estimated by analyzing historical rate change patterns from 2013 to 2022 and applying these trends to the 2022 ADA survey data.

The dental IDD service grouping has 444 procedure codes. The rates for 191 of them (43.02%) were compared to ADA. Among these 191 codes, 89 of them (46.60%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for these 191 dentalIDD codes were 17.67% - 141.11%.

On average, Colorado Medicaid payments for these 191 dental IDD codes are estimated at 74.65% of the benchmark. DIDD data was provided by DentaQuest, with only eight months of data available at the time of this analysis. A summary of the

estimated total expenditures resulting from using comparable sources is presented below.

DIDD Repriced Benchmark Comparison		
Colorado Repriced	ADA Repriced	Overall Repriced Benchmark Ratio
\$5,087,087	\$6,814,427	74.65%

Table 13. Comparison of Colorado Medicaid DIDD service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,727,340 total funds if Colorado had reimbursed at 100% of the benchmark.

Benchmark States

After investigating all 50 states in the US, the following 5 benchmark states were chosen as benchmark states for the rate comparison analysis: Louisiana, Nevada, New York, Oklahoma, and South Carolina. These states either have separate Dental Fee Schedules, or additional coverage, or enhanced reimbursement rates for IDD population.

Among the 444 dental IDD procedure codes, the rates for 100 of them (22.52%) were compared to the rates from these benchmark states. Among these 100 codes, 25 of them (25%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for these 100 DIDD codes were 37.90% - 287.38%.

On average, Colorado Medicaid payments for these 100 dental IDD codes are estimated at 177.25% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below for the eight months of data.

DIDD Repriced Benchmark Comparison		
Colorado Repriced	Benchmark State Repriced	Overall Repriced Benchmark Ratio
\$4,032,356	\$2,274,902	177.25%

Table 14. Comparison of Colorado Medicaid DIDD service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$1,757,454 total funds if Colorado had reimbursed at 100% of the benchmark.

Conclusions and Indications

1. Compared to regular CO Medicaid Dental State Plan, dental IDD reimbursement rates have a 131.00% overall benchmark ratio, indicating the DIDD rates are significantly more supportive of provider reimbursement. But 15 of the 196 comparable codes (7.65%) are under-benchmarked which may create pockets of undercompensation for certain procedures.
2. Compared to predicted ADA 2025 rates, CO's dental IDD reimbursement rates have a 74.65% overall benchmark ratio, indicating that our rates are significantly lower than projected 2025 market rate based on 2022 national commercial dental survey data with trend adjustments.
3. Compared to benchmark states with enhanced IDD dental programs, CO's DIDD rates are at 177.25%, suggesting that Colorado has adopted a much more supportive reimbursement approach for IDD dental care than peer states.

The disparity between the last two benchmarks indicates that while Colorado may be leading among states in investing in dental services for the IDD population, the rates may still fall below what is typically charged in the broader commercial dental market. This finding suggests a need to balance fiscal responsibility with rate adequacy to ensure continued access and sustainability of care for individuals with IDD.

Access to Care Analysis

As seen in the dental IDD panel size visual (Appendix B, Figure 12), the average number of utilizers per provider remained stable in urban and rural regions. The special providers visual (Appendix B, Figure 15) shows that the percent of active providers that serve only one Medicaid member remained stable. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

Extensive engagement with both internal and external stakeholders occurred during the dental IDD rate review process to inform, discuss, and negotiate the selection of the benchmark sources.

1. Internal Stakeholder: Because of the limitations with the ADA survey data, HCPF decided to include additional benchmark options beyond using 2022 ADA data. Policy specialists from HCBS Benefits Team and Policy Innovation & Benefit Team in the Health Policy Office were first consulted to understand what makes dental IDD services unique and what factors to consider when choosing benchmark states.

Based on their inputs, dental programs in all 50 states were reviewed and five states with enhanced IDD dental services were selected. The policy specialists reviewed these programs and agreed they were appropriate benchmarks.

2. External Stakeholder: As part of our rate review process, key external stakeholders are engaged to ensure transparency and inclusivity in our benchmarking approach. Specifically, the Colorado Dental Hygienists' Association (CODHA) and the Colorado Dental Association (DCA) were reached to gather their feedback on appropriate rate comparison methodologies for DIDD dental services.

Both organizations expressed support for using the ADA 2022 survey data (with appropriate trend adjustments) and the selection of benchmark states as reasonable approaches. During these discussions, stakeholders also suggested exploring additional benchmarks, including the Worker's Compensation Dental Fee Schedule and the National Dental Advisory Service (NDAS) fee schedule. Upon further review, we identified important limitations with both alternatives:

- Workers' Compensation Dental Program⁶: This program is funded differently from Medicaid and is subject to open-ended medical liability, which, according to the National Council on Compensation Insurance (NCCI), underscores the need for effective cost control⁷. In addition, the workers' compensation population generally experience acute, injury-based dental needs that are often more costly to treat, while IDD members typically have lifelong disabilities present from birth.
- NDAS Fee Schedule⁸: Access to NDAS fee schedule requires a paid subscription, and its use may involve copyright limitations. Disclosing fee information from NDAS could present legal challenges, potentially compromising compliance. On the other hand, not disclosing those rates would undermine the transparency of our rate-setting methodology, which is essential for accountability in public programs.

Based on these considerations, we proceeded with ADA data and benchmark state comparisons as our primary benchmarks, as they best balance relevance, transparency, and legal compliance.

See Appendix I for Stakeholder Feedback.

⁶ For Colorado Workers' Compensation, please refer to <https://cdle.colorado.gov/dwc> for details.

⁷ Please refer to https://www.ncci.com/Articles/Pages/II_Research-wc-vs-group-health.pdf for more details.

⁸ Please refer to <https://wasserman-medical.com/product-category/dental/ndas/> for NDAS Fee Schedules.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for dental IDD services.

DIDD Top 10 Procedure Codes by Utilization						
Rank	Code	Service Description	Benchmark Ratio (ADA)	Benchmark Ratio (Benchmark States)	Utilization	% of Total Utilization
1	D0120	Periodic Oral Evaluation	75.0%	153.5%	6,513	14.91%
2	D1110	Prophylaxis Adult	81.1%	166.7%	5,479	12.55%
3	D1206	Topical Fluoride Varnish	76.3%	112.0%	3,364	7.70%
4	D0230	Intraoral Periapical-Each Additional	72.3%	215.5%	2,569	5.88%
5	D0274	Bitewings, Four Images	74.1%	187.6%	2,560	5.86%
6	D0220	Intraoral Periapical First	72.3%	143.3%	2,362	5.41%
7	D4910	Periodontal Maintenance	74.9%	225.4%	1,806	4.14%
8	D4342	Periodontal Scaling 1 to 3 Teeth	76.1%	219.1%	1,707	3.91%
9	D7140	Extraction Erupted Tooth/Exposed Root	65.8%	172.2%	1,268	2.90%
10	D2392	Resin Based Composite Two Surfaces Posterior	70.3%	208.5%	1,253	2.87%

Table 15. DIDD top 10 procedure codes ranked by utilization

Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the IDD population. Preventive services play a critical role in reducing the need for more complex procedures, especially for individuals with IDD who may face greater barriers to accessing routine dental care.

This analysis showed that only 69% (Table 16) of the IDD population who used dental services received preventive dental care in SFY 2023-24. Other than potential access barriers, the underutilization of these codes may be due to the following two contributing factors:

1. Dental claims are first processed under the State plan. Services that have been maxed or denied on the State plan are then submitted for adjudication under the IDD plan.
2. The SFY 2023-24 data has some limitations, as DentaQuest provided records only from July 2023 to Feb 2024, leaving a data gap from March to June 2024.

	Number of Codes	Member Count	Utilization	Net Paid Amount
Preventive Codes	17	3,658	9,358	\$504,701
All DIDD Codes	444	5,296	44,100	\$4,552,421
Percentage of Preventative Codes Over All DIDD Codes	4%	69%	21%	11%

Table 16. DIDD preventive codes analysis

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are below 60% or above 140% of the benchmark rate.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Dental for People with Intellectual and Developmental Disabilities Compared to Projected ADA 2025 Rates

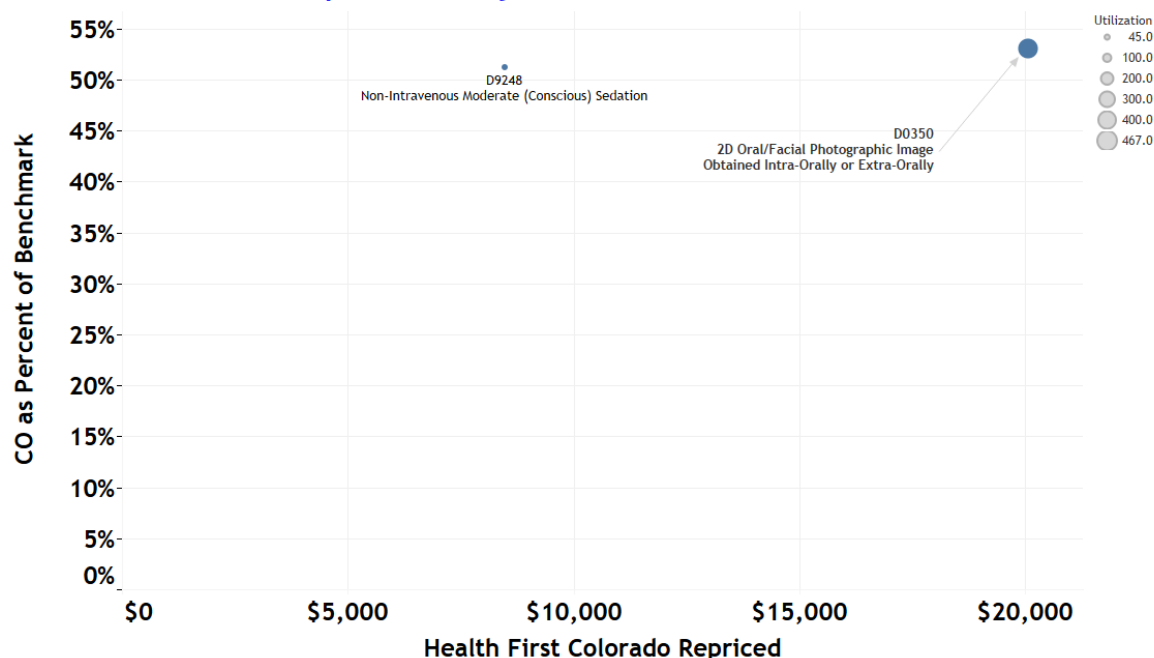


Figure 1. Bubble Chart indicating the outliers under 60% and over 140% found for DIDD compared to Projected ADA 2025 rates

The bubble chart above (Figure 1) indicates that there are two procedure codes with CO rates below 60% of the benchmark using projected ADA 2025 rates for benchmarking for dental IDD services. Code D9248 has a benchmark ratio of 51% with 45 allowed units, accounting for only 0.15% of total utilization in this service group. Code D0350 has a benchmark ratio of 53% with 467 allowed units (15.87% of the total). To protect PHI, seven outliers with low utilization were excluded from the chart, all of them have a benchmark ratio below 60%.

The bubble chart below (Figure 2) indicates that there is one procedure code (D4346), with CO rates under 60% of the benchmark using other states for benchmarking for DIDD. And there are 47 codes (see Appendix A2 for more details), with rates above 140% of the benchmark rate. To protect PHI, 24 outliers with low utilization were excluded from the chart, all of them have a benchmark ratio above 140%.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Dental for People with Intellectual and Developmental Disabilities Compared to Benchmark States Rates

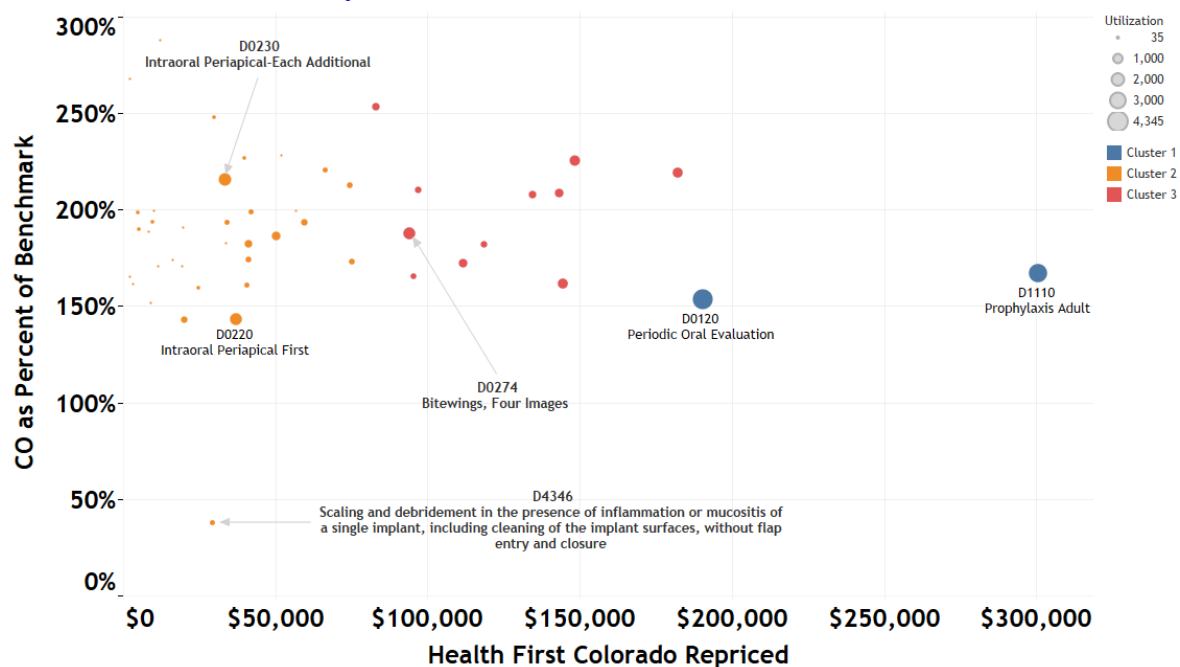


Figure 2. Bubble Chart indicating the outliers under 60% and over 140% found for DIDD compared to Benchmark States

These 48 outliers are grouped into 3 clusters:

- Cluster 1 includes 2 codes with utilization amounts between 3,655 and 4,345 allowed units, and repriced amounts between \$190,318 and \$300,726. The benchmark ratio for these codes ranges between 153.43% and 166.74%. Cluster 1 contains outliers with the highest utilization and high Colorado repriced amounts.
- Cluster 2 includes 35 codes with utilization amounts between 35 and 1,714 allowed units, and repriced amounts between \$2,241K and \$75,298K. The benchmark ratio for these codes ranges between 37.90% and 287.38%. Overall, cluster 2 contains outliers with low Colorado repriced amounts and low to moderate utilization.
- Cluster 3 includes 11 codes with utilization amounts between 423 and 1,708 allowed units, and repriced amounts between \$83,055 and \$182,343. The benchmark ratio for these codes ranges between 161.75% and 253.01%. Overall, cluster 3 contains outliers with moderate utilization as well as moderate Colorado repriced amount.

MPRRAC Recommendations

- The MPRRAC recommends increasing rates that are below 100% of the regular Medicaid dental rates in the State Plan to 150% of those rates, and keeping any rates that are at or above 100% of the State Plan levels the same.
- The MPRRAC recommends adjusting the rates for the three highly used codes (D00120, D7140, and D2392) to 150% of the standard Medicaid dental rates in the State Plan, acknowledging that the current rates are set higher than the State Plan rates.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,073,485 total funds, including \$207,934 General Fund, when extrapolated to a full year.

HCPF Recommendations

- HCPF recommends adjusting all rates for codes covered in the Colorado Medicaid Dental State Plan to 125% of the State Plan rates.
- HCPF recommends no changes for codes not covered in the Colorado Medicaid Dental State Plan.
- HCPF recommends no changes for codes with a \$0 rate or those that are manually priced.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$51,223 total funds, including -\$9,922 General Fund, when extrapolated to a full year.

Durable Medical Equipment (DME)

Service Description

DME includes items that are primarily and customarily used to serve a medical purpose. Generally, they are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable.

DME Statistics	
Total Adjusted Expenditures SFY 2023-24	\$73,936,431
Total Members Utilizing Services in SFY 2023-24	85,192
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-14.77%
Total Active Providers SFY 2023-24	3,723
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.70%

Table 17. DME total expenditure and utilization data (SFY 2023-24).

Benchmark Rationale

The rates for DME were compared to Medicare and the rates from 6 benchmark states: Arizona, California, Nebraska, Oklahoma, Oregon, and Wyoming. These states were chosen as benchmarks for the rate comparison analysis collectively because they cover many of the same DME services. Additionally, most of the benchmark states are geographically close to Colorado and share provider operating groups and networks. The ability to review rate differentials between geographics is beneficial for reviewing DME rates. Hence, some of the states have higher amounts of covered populations in rural areas, providing a rural and urban split for reimbursement that is similar to the rural and urban split in Colorado. When comparing procedure code/modifier/region combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definitions. This leads to inconsistencies in the number of benchmark states available for different codes. For more information on the benchmark states used for a particular code, please see Appendix D.

Rate Comparison Analysis

The DME service grouping has a total of 1,141 procedure code/modifier/region combinations. The benchmarks for 511 combinations were calculated using the Colorado and benchmark repriced amounts because those combinations had valid SFY 2023-24 utilization data. The benchmarks for 422 combinations were calculated using rate-only comparisons because there was no valid SFY 2023-24 utilization data. In total, 933 of these combinations have a benchmark. The rates for 599 combinations (52.5%) were compared to Medicare, and the rates for 334 combinations (29.3%) were compared to rates from benchmark states. Moreover, 208 combinations (18.2%) were excluded; these exclusions include 89 combinations that do not have a Colorado rate, either because the code is closed (1) or because the code is manually priced (88), and 119 combinations that do not have a valid benchmark.

On average, Colorado Medicaid payments for DME are estimated to be at 91.71% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DME Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$73,936,431	\$80,619,213	91.71%

Table 18. Comparison of Colorado Medicaid DME service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$6,682,782 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for DME were 3.39%-486.84%.

Access to Care Analysis

As seen in the DME panel size visual (Appendix B, Figure 16), the average number of utilizers per provider in urban regions increased before decreasing. The penetration rate visual (Appendix B, Figure 18) shows that much of South-Eastern Colorado had considerably high or otherwise moderate penetration rates. The percentage of active providers serving Medicaid members was 28% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 19) shows that the percent of active providers that served only one Medicaid member had an increasing trend, which was a result of more DME online retailers that enable delivery to members' homes. These findings suggest that access to care is relatively stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

Through various engagement with stakeholders, two key issues were brought to light. Stakeholders were interested in the manually priced codes, and the MPRRAC was interested in key codes with benchmark ratios above 100% of the benchmark. These issues were addressed through the following processes.

In response to comments during the March 2025 meeting, which highlighted stakeholder interest in manually priced codes, all manually priced codes were added to Appendix A2. Moreover, HCPF met with the stakeholders and learned that most of the manually priced codes of interest fall under the orthotics subcategory.

Through discussions with internal policy specialists, K0739 (repair/service for DME non-oxygen equipment) was highlighted as a critical code in the DME benefit. This code reimburses for the labor involved in a repair. It is priced to encourage suppliers to repair equipment when appropriate rather than purchasing new equipment. While this code is at 225% of the benchmark, its rate is important for cost savings.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier/region combinations with the highest utilization for DME.

DME Top 10 Procedure Codes by Utilization						
Rank	Code + Modifier	Region	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	E1390+RR	Urban	OXYGEN CONCENTRATOR	99.04%	146,679	28.55%
2	E0431+RR	Urban	PORTABLE GASEOUS O2	85.51%	67,642	13.17%
3	E1390+RR	Rural	OXYGEN CONCENTRATOR	82.21%	34,494	6.71%
4	K0738+RR	Urban	PORTABLE GAS OXYGEN SYSTEM	80.80%	31,241	6.08%
5	E0431+RR	Rural	PORTABLE GASEOUS O2	82.09%	18,704	3.64%
6	K0739	Statewide	REPAIR/SVC DME NON-OXYGEN EQ	225.42%	17,158	3.34%
7	E0601+RR	Urban	CONT AIRWAY PRESSURE DEVICE	98.04%	13,107	2.55%
8	A4627	Statewide	SPACER BAG/RESERVOIR	148.25%	12,616	2.46%
9	E1392+RR	Urban	PORTABLE OXYGEN CONCENTRATOR	81.05%	10,568	2.06%
10	E0424+RR	Urban	STATIONARY COMPRESSED GAS O2	99.05%	10,488	2.04%

Table 19. DME top 10 procedure codes by utilization.

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. The below bubble charts indicate the outliers under 60%

and above 140% found for DME. To protect PHI, 24 outliers with low utilization were excluded from the charts; 14 of these were outliers with benchmark ratios below 60%, and 10 of these were outliers with benchmark ratios above 140%.

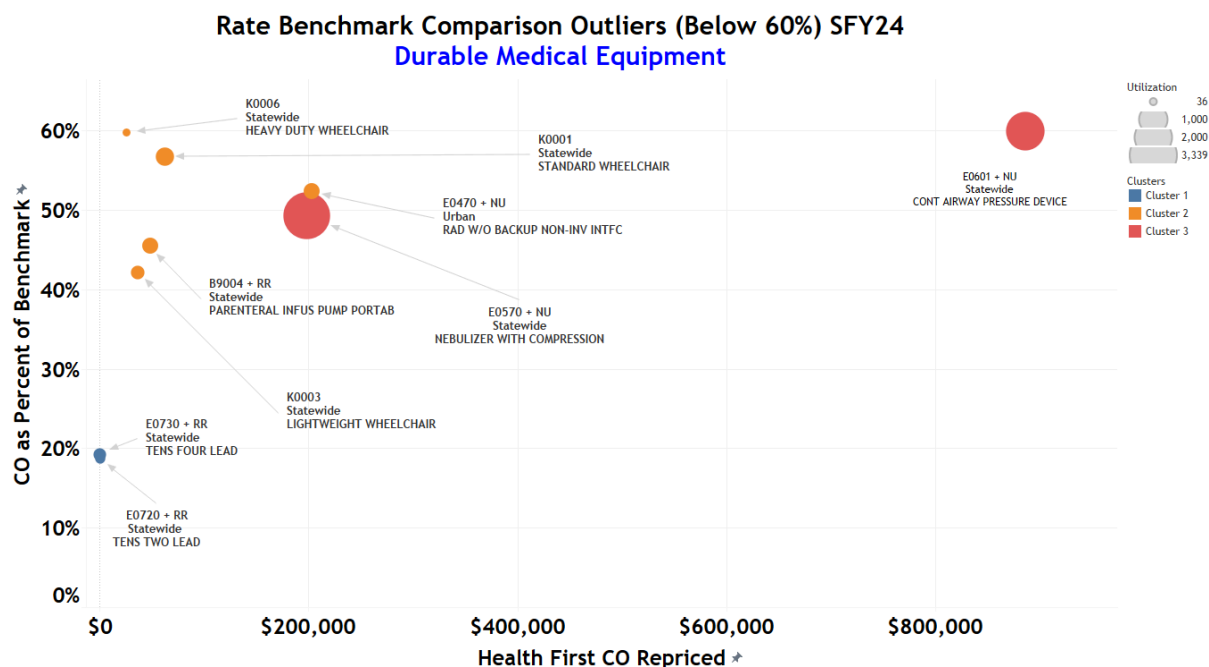


Figure 3. Bubble Chart indicating the outliers under 60% for DME.

In Figure 3, there are 9 outliers with Colorado repriced amounts and benchmark ratios under 60% of the benchmark. These outliers are grouped into three clusters.

- Cluster 1 includes two procedure code/modifier/region combinations, E0720 + RR and E0730 + RR, and they are both around 19% of the benchmark. Their Colorado repriced amounts are \$262 and \$480, and their utilization amounts are 47 and 84 allowed units, respectively. Overall, cluster 1 contains outliers with low utilization, low Colorado repriced amounts, and low benchmark ratios.
- Cluster 2 includes five procedure code/modifier/region combinations, K0001, K0003, K0006, B9004 + RR, and E0470 + NU + Urban. Their benchmark ratios range from 42% to 60%, their Colorado repriced amounts range from \$25,446 to \$202,790, and their utilization ranges from 36 to 270 allowed units. Overall, cluster 2 contains outliers with low utilization, low Colorado repriced amounts, and relatively moderate benchmark ratios.
- Cluster 3 includes two procedure code/modifier/region combinations, E0570 + NU and E0601 + NU. Their benchmark ratios are 49% and 60%, their Colorado repriced amounts are \$198,550 and \$886,110, and their utilization amounts are

3,339 and 2,089, respectively. Overall, cluster 3 contains outliers with relatively high utilization and relatively moderate benchmark ratios.

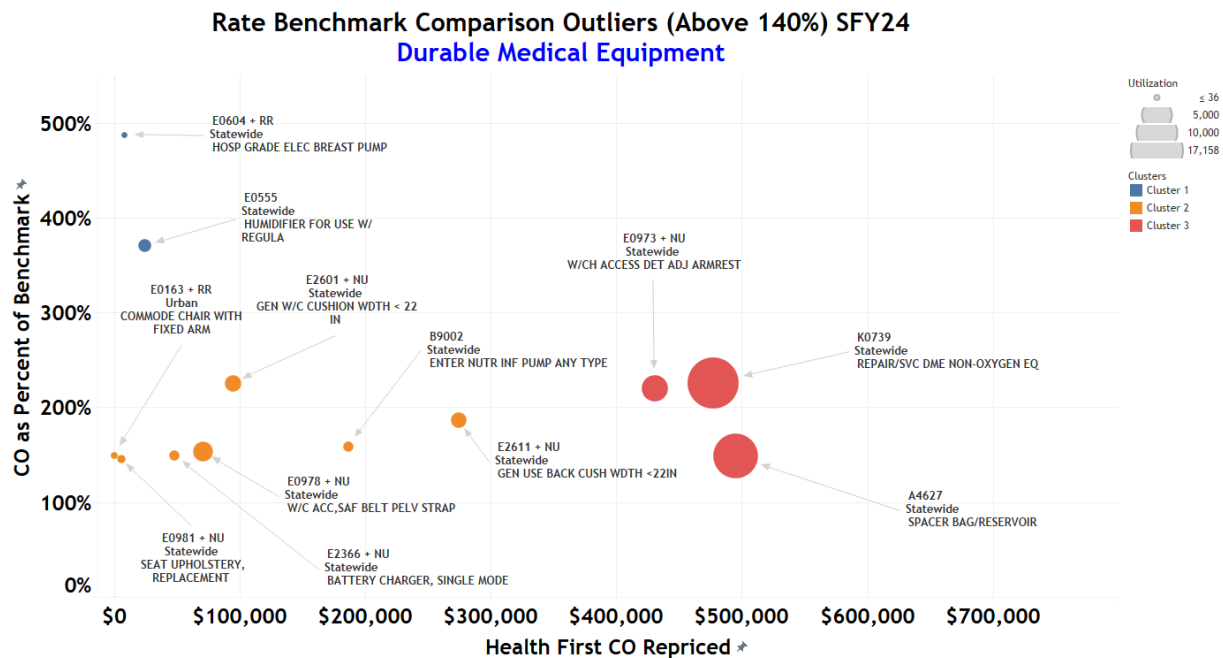


Figure 4. Bubble Chart indicating the outliers over 140% for DME.

In Figure 4, there are 12 outliers with Colorado repriced amounts and benchmark ratios above 140% of the benchmark. These outliers are grouped into three clusters.

- Cluster 1 includes two procedure code/modifier/region combinations, E0555 and E0604 + RR. Their benchmark ratios are 371% and 487%, their Colorado repriced amounts are \$24,420 and \$8,078, and their utilization amounts are 430 and 35 allowed units, respectively. Overall, cluster 1 contains outliers with high benchmark ratios, low utilization, and low Colorado repriced amounts.
- Cluster 2 includes seven procedure code/modifier/region combinations. Their benchmark ratios range from 145% to 225%, their Colorado repriced amounts range from \$432 to \$274,380, and their utilization ranges from 44 to 1,634 allowed units. Overall, cluster 2 contains outliers that have relatively moderate benchmark ratios, low utilization, and relatively low Colorado repriced amounts.
- Cluster 3 includes three procedure code/modifier/region combinations, A4627, E0973 + NU, and K0739. Their benchmark ratios range from 148% to 225%, their Colorado repriced amounts range from \$430,444 to \$494,918, and their utilization ranges from 3,487 to 17,158 allowed units. Overall, cluster 3

contains outliers with relatively moderate benchmark ratios, high utilization, and high Colorado repriced amounts.

MPRRAC Recommendations

- For DME services, the MPRRAC recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes that are above 80% of the benchmark the same.
- For codes with valid Colorado rates but without benchmark ratios, the MPRRAC recommends an increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,039,849 total funds, including \$285,127 General Fund.

HCPF Recommendations

- For DME services, HCPF recommends increasing the rates for all codes that are under 70% of the benchmark ratio to 70% of the benchmark and decreasing the rates for all codes that are above 100% of the benchmark to 100% of the benchmark due to budget constraints. However, HCPF recommends keeping the rate for code K0739⁹, non-oxygen equipment repair, the same. This rebalancing of rates is recommended due to many codes being significantly below their respective benchmarks. However, due to budget constraints and the current uncertainties about the impact of tariffs on this category the codes that are currently above 100% of their respective benchmarks need to be lowered in order to make up for the extra expenditure.
- For codes with valid Colorado rates but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$1,434,889 total funds, including -\$393,447 General Fund.

⁹ Repair code K0739 is a critical code in the DME benefit, as it facilitates cost savings, aligning with the Medicaid Sustainability Framework.

Prosthetics, Orthotics, Enteral Formula, and Disposable Supplies - Overview

Service Description

Prosthetic and orthotic devices are defined as replacement, corrective, or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body. They often come with disposable supplies that are related to these treatments.

Services included under this category are:

- Prosthetics
- Orthotics
- Enteral Formula
- Other and Disposable Supplies

Benchmark Rationale

The rates for prosthetics, orthotics and disposable supplies were compared to Medicare and the rates from 10 benchmark states: Arizona, California, Louisiana, Nebraska, Nevada, Ohio, Oklahoma, Oregon, Texas and Wyoming. These states were chosen as benchmarks for the rate comparison analysis because they collectively cover many of the same prosthetics, orthotics, and disposable supplies services. Additionally, most of the benchmark states are geographically close to Colorado and share provider operating groups and networks. The ability to review rate differentials between geographics is beneficial for reviewing prosthetics, orthotics, and disposable supplies rates. Hence, some of the states have higher amounts of covered populations in rural areas, providing a rural and urban split for reimbursement that is similar to the rural and urban split in Colorado. This service category contains over one hundred unique procedure codes not covered by Medicare; hence, ten states are used for benchmarking to allow for a more complete analysis of the category. When comparing procedure code/modifier/region combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definitions. This leads to inconsistencies in the number of benchmark states available for different codes. For more information on the benchmark states used for a particular code, please see Appendix D.

Prosthetics, Orthotics, and Disposable Supplies (POS) - Prosthetics

Service Description

Prosthetics services provide specialized healthcare solutions for individuals who have lost limbs or body parts due to amputation, injury, or congenital conditions. These services focus on the design, fabrication, fitting, and maintenance of artificial limbs and body parts called prostheses.

POS - Prosthetics Statistics	
Total Adjusted Expenditures SFY 2023-24	\$7,009,735
Total Members Utilizing Services in SFY 2023-24	870
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-7.64%
Total Active Providers SFY 2023-24	64
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-4.48%

Table 20. Prosthetics total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The prosthetics service grouping has a total of 419 procedure code/modifier/region combinations. The benchmarks for 202 combinations were calculated using the Colorado and benchmark repriced amounts because those combinations had valid SFY 2023-24 utilization data. The benchmarks for 201 combinations were calculated using rate-only comparisons because there was no valid SFY 2023-24 utilization data. In total, 403 of these combinations have a benchmark. The rates for 397 combinations (94.8%) are compared to Medicare, and the rates for six combinations (1.4%) are compared to rates from benchmark states. Moreover, 16 combinations (3.8%) are excluded because the codes are manually priced and do not have a Colorado rate.

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

POS - Prosthetics Benchmark States	
Procedure Code	Benchmark States
L7510	Louisiana, Nevada, Ohio, Oklahoma, Oregon, Texas, and Wyoming
L7520	Arizona, California, Louisiana, Nebraska, Nevada, Ohio, Oklahoma, Oregon, Texas, and Wyoming
L8010	Arizona, California, Louisiana, Nebraska, Nevada, Ohio, Oklahoma, Texas, and Wyoming
L8049	Arizona, Nebraska, Oregon, and Wyoming
L8505	Louisiana, Nebraska, and Oregon
L8692	Ohio, Oklahoma, Oregon, Texas, and Wyoming

Table 21. Prosthetics benchmark states (SFY 2023-24).

On average, Colorado Medicaid payments for prosthetics are estimated at 74.07% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

POS - Prosthetics Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 10 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$7,009,735	\$9,463,047	74.07%

Table 22. Comparison of Colorado Medicaid prosthetics service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$2,453,312 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for prosthetics were 6.87%-246.28%.

Access to Care Analysis

As seen in the prosthetics panel size visual (Appendix B, Figure 21), the average number of utilizers per provider in urban and rural areas was stable. The percentage of active providers that served Medicaid members was 29% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 24) shows that the percent of active providers that served only one Medicaid member increased before decreasing. The drive time analysis (Appendix B, Figure 25) shows that much of the state had relatively high drive times (over an hour). These findings indicate that access to care could be impacted by relatively low provider participation and longer distances to providers.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier/region combinations with the highest utilization for prosthetics.

POS - Prosthetics Top 10 Procedure Codes by Utilization						
Rank	Code + Modifier	Service Description	Region	Benchmark Ratio	Utilization	% of Total Utilization
1	L8420	PROSTHETIC SOCK MULTI PLY BK	Statewide	71.01%	2,628	19.44%
2	L8470	PROS SOCK SINGLE PLY BK	Statewide	71.25%	1,919	14.19%
3	L5673	SOCKET INSERT W LOCK MECH	Statewide	79.08%	712	5.27%
4	L5620	TEST SOCKET BELOW KNEE	Statewide	71.11%	520	3.85%
5	L8400	SHEATH BELOW KNEE	Statewide	71.41%	511	3.78%
6	L5679	SOCKET INSERT W/O LOCK MECH	Statewide	78.90%	432	3.20%
7	L5685	BELOW KNEE SUS/SEAL SLEEVE	Statewide	71.18%	373	2.76%
8	L8430	PROSTHETIC SOCK MULTI PLY AK	Statewide	71.40%	373	2.76%
9	L5637	BELOW KNEE TOTAL CONTACT	Statewide	71.10%	360	2.66%
10	L5940	ENDO BK ULTRA-LIGHT MATERIAL	Statewide	71.13%	329	2.43%

Table 23. Prosthetics top 10 procedure codes by utilization.

MPRRAC Recommendations

- For POS - prosthetics services, the MPRRAC recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes that are above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$564,395 total funds, including \$154,757 General Fund.

HCPF Recommendations

- For POS - prosthetics services, HCPF recommends no changes to the rates due to current uncertainties about the impact of tariffs on this category.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Prosthetics, Orthotics, and Disposable Supplies - Orthotics

Service Description

Orthotics services focus on the design, fabrication, and application of external devices, which are called orthoses, to support, align, or correct various parts of the body.

POS - Orthotics Statistics	
Total Adjusted Expenditures SFY 2023-24	\$13,302,280
Total Members Utilizing Services in SFY 2023-24	27,142
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-1.64%
Total Active Providers SFY 2023-24	241
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.00%

Table 24. Orthotics total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The orthotics service grouping has a total of 500 procedure code/modifier/region combinations. The benchmarks for 291 combinations were calculated using the Colorado and benchmark repriced amounts because those combinations had valid SFY 2023-24 utilization data. The benchmarks for 192 combinations were calculated using rate-only comparisons because there was no valid SFY 2023-24 utilization data. In total, 483 of these combinations have a benchmark. The rates for 432 combinations (86.4%) are compared to Medicare, and the rates for 51 combinations (10.2%) are compared to rates from benchmark states. Moreover, 17 combinations (3.4%) are excluded; these exclusions include 11 combinations that do not have a Colorado rate, either because the code is closed (1) or because the code is manually priced (10), and 6 combinations that do not have a valid benchmark.

On average, Colorado Medicaid payments for orthotics are estimated at 82.66% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

POS - Orthotics Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 10 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$13,302,280	\$16,091,959	82.66%

Table 25. Comparison of Colorado Medicaid orthotics service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$2,789,679 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for orthotics were 26.85%-307.43%.

Access to Care Analysis

As seen in the orthotics panel size visual (Appendix B, Figure 27), the average number of utilizers per provider in urban areas experienced an increasing trend with noted fluctuations throughout SFY 2021-22 and SFY 2022-23. It then decreased notably into the middle of SFY 2023-24, before increasing again and experiencing similar fluctuations as the previous years. The percentage of active providers that served Medicaid members was 39% in SFY 2023-24. The special providers visual (Appendix B, Figure 30) shows that the percent of active providers that served only one Medicaid member remained stable. The drive time analysis (Appendix B, Figure 31) shows that drive times were relatively low statewide, with the exception of some parts of Western Colorado. However, the context provided by the panel size map (Appendix B, Figure 28) and penetration rate visual (Appendix B, Figure 29) indicates that access to care is relatively stable, even for most of the Western Colorado counties affected by higher drive times.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

Extensive engagement with both internal and external stakeholders occurred during the orthotics rate review process. There were two main stakeholder groups with feedback regarding the orthotics category.

First, stakeholders from the American Orthotic and Prosthetic Association (AOPA) made the following requests:

- Normal FFS fee schedule reimbursement methodology for codes L5973 and L6880, which are manually priced on the Health First Colorado fee schedule.
- Miscellaneous 99 codes (i.e., L2999) to be priced at cost + 70% rather than the current cost + 24.06%. This request would require a budget increase.
- Health First Colorado covers L2006 MP-KAFO (not currently a Health First Colorado benefit)

Since these requests are for procedure codes that are not currently reimbursed through the normal FFS fee schedule methodology, stakeholders from AOPA were connected with the DMEPOS policy specialists to formally request these changes. The policy specialists have met with and communicated via email with stakeholders from AOPA. The requests must go through the Benefit Determination Process.

Second, HCPF reached out to stakeholders from Cranial Kids and Cranial Tech regarding procedure code S1040, as this code was identified as a critical code by the DMEPOS policy team. Many stakeholders were able to attend the July meeting to present their feedback on this procedure code.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the code/modifier/region combinations with the highest utilization for orthotics.

POS - Orthotics Top 10 Procedure Codes by Utilization						
Rank	Code + Modifier	Service Description	Region	Benchmark Ratio	Utilization	% of Total Utilization
1	L2275	PLASTIC MOD LOW EXT PAD/LINE	Statewide	70.12%	4,290	6.75%
2	L4361	PNEUMA/VAC WALK BOOT PRE OTS	Statewide	71.18%	3,714	5.84%
3	L2840	TIBIAL LENGTH SOCK FX OR EQU	Statewide	70.02%	3,617	5.69%
4	L3908	WHO COCK-UP NONMOLDE PRE OTS	Statewide	71.31%	3,239	5.10%
5	L2820	SOFT INTERFACE BELOW KNEE SE	Statewide	70.43%	2,785	4.38%
6	L2280	MOLDED INNER BOOT	Statewide	69.98%	2,725	4.29%
7	L0621	SIO FLEX PELVIC/SACR PRE OTS	Statewide	123.47%	2,157	3.39%
8	L3202	OXFORD W/ SUPINAT/PRONATOR C	Statewide	107.63%	2,035	3.20%
9	L3670	SO ACRO/CLAV CAN WEB PRE OTS	Statewide	47.96%	2,013	3.17%
10	L3809	WHFO W/O JOINTS PRE OTS	Statewide	71.15%	1,991	3.13%

Table 26. Orthotics top 10 procedure codes by utilization.

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category. The below bubble chart (Figure 5) indicates the outliers under 60% or above 140% found for orthotics. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, 15 outliers with low utilization were excluded from the chart. Out of these low-utilized outliers, 12 were below 60% of the benchmark and 3 were above 140% of the benchmark.

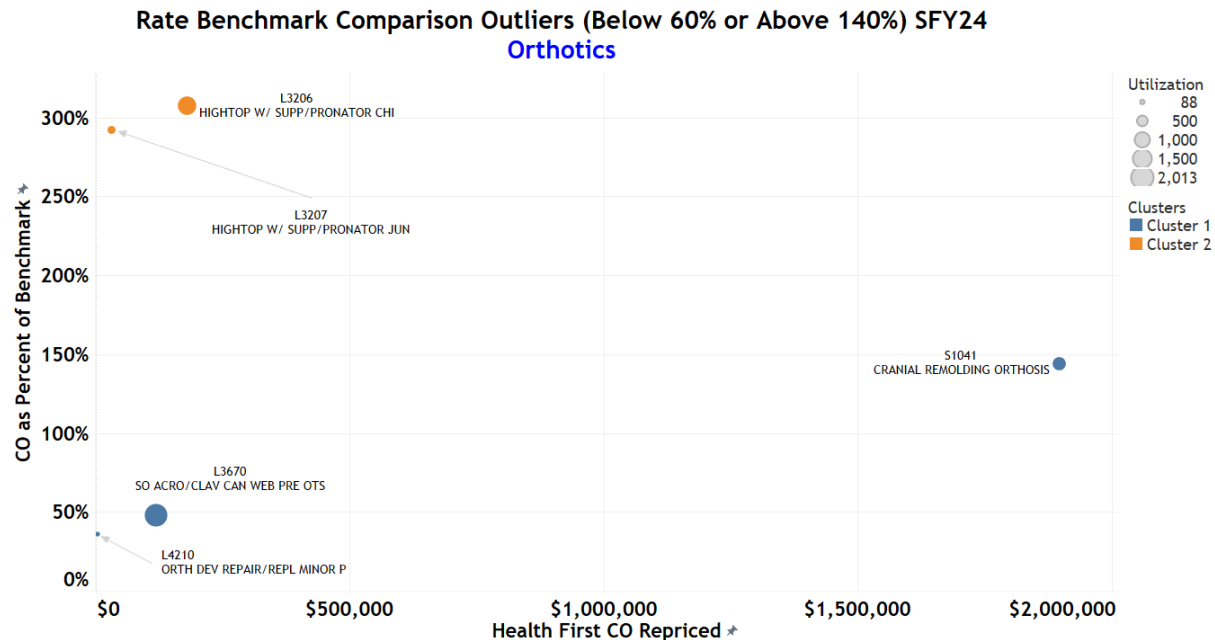


Figure 5. Bubble chart indicating the outliers below 60% and over 140% for orthotics.

In Figure 5, there are 5 outliers with Colorado repriced amounts and benchmark ratios under 60% of the benchmark. These outliers are grouped into two clusters.

- Cluster 1 is composed of three outliers. Within this cluster, there are two outliers, L3670 and L4210, with valid SFY 2023-24 utilization that are under 60% of the benchmark. Moreover, there is one outlier, S1041, with valid SFY 2023-24 utilization that is at 144% of the benchmark. Among the outliers, S1040 had the highest Health First Colorado repriced amount of \$1,897,719 (14% of the total Health First Colorado repriced amount in the orthotics category). In addition, L3670 had the highest utilization at just over 2000 allowed units (3% of the overall utilization in the orthotics category), and L4210 had the lowest utilization at 88 allowed units (0.1% of the overall utilization in the orthotics category).
- Cluster 2 contains two outliers with benchmark ratios above 290%. These outliers all had Health First Colorado repriced amounts ranging from around \$10,000-\$60,000. Their utilization amounts range between 256 and 1,337 allowed units.

MPRRAC Recommendations

- For POS - orthotics services, the MPRRAC recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark

and to keep the rates for all codes that are above 80% of the benchmark the same.

- For codes with valid Colorado rates but without benchmark ratios, the MPRRAC recommends an increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,067,224 total funds, including \$292,633 General Fund.

HCPF Recommendations

- For POS - orthotics services, HCPF recommends increasing the rates for all codes that are under 70% of the benchmark ratio to 70% of the benchmark and decreasing the rates for all codes that are above 100% of the benchmark to 100% of the benchmark due to budget constraints. However, HCPF recommends keeping the rate for code S1040¹⁰, cranial molding orthosis, the same.
- For codes with valid Colorado rates but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$222,925 total funds, including -\$61,126 General Fund.

¹⁰ The rate for code S1040 covers the entire process, including the creation of the orthosis, fitting it to the infant, and making necessary adjustments. This rate was set in a way to ensure access to care and properly reimburse providers for this service.

Prosthetics, Orthotics, and Disposable Supplies - Enteral Formula

Service Description

Enteral formula is a liquid, nutrient-rich food or supplement designed to be delivered directly into the gastrointestinal (GI) tract either orally or through a feeding tube. It is designed to meet nutritional needs when someone cannot consume enough food or nutrients orally due to medical conditions that impair normal digestion or absorption. These formulas may be nutritionally complete or specialized for specific medical conditions. Enteral formula is ordered by a physician, physician assistant, or nurse practitioner and provided according to standards of practice. Under appropriate circumstances, enteral formula may be covered under Medicare Part B when medical necessity criteria are met.

POS - Enteral Formula Statistics	
Total Adjusted Expenditures SFY 2023-24	\$28,938,450
Total Members Utilizing Services in SFY 2023-24	10,243
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	4.03%
Total Active Providers SFY 2023-24	119
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	12.26%

Table 27. Enteral formula total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The enteral formula service grouping has a total of 32 procedure code/modifier/region combinations. The rates for 19 combinations (59.4%) are compared to Medicare, and the rates for 8 combinations (25%) are compared to rates from benchmark states. Moreover, 5 combinations (15.6%) are excluded because they are manually priced, which means they do not have a Colorado rate.

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

POS - Enteral Formula Benchmark States	
Procedure Code	Benchmark States
B4102	Louisiana and Ohio
B4157	Nevada, Oregon, and Texas
B4158, B4159, B4160, B4161	Louisiana, Nebraska, Nevada, Oregon, and Texas
B4172	Nebraska, Oklahoma, Oregon, and Texas
B5200	Oregon and Texas

Table 28. Enteral formula benchmark states (SFY 2023-24).

On average, Colorado Medicaid payments for enteral formula are estimated at 141.52% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

POS - Enteral Formula Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 10 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$28,938,451	\$20,448,060	141.52%

Table 29. Comparison of Colorado Medicaid enteral formula service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$8,490,391 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for the enteral formula category were 15.03%-329.31%.

Access to Care Analysis

As seen in the enteral formula panel size visual (Appendix B, Figure 33), the average number of utilizers per provider in urban areas decreased then increased. The special providers visual (Appendix B, Figure 201) shows that the percent of active providers that served only one Medicaid member increased. These findings indicate that access to care is relatively stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

Extensive engagement with both internal and external stakeholders occurred during the enteral formula rate review process. Policy specialists were consulted to determine why Health First Colorado rates differ from Medicare rates, as 12 codes above 100% of the benchmark account for 99% of the utilization. There are 100-474 formula products assigned to each procedure code, and these products have different pricing structures. Medicare covers the standard (low-cost) adult formulas, while Health First Colorado covers many specialty pediatric formulas that have higher costs. More than two-thirds of the Health First Colorado expenditure for enteral formula is for pediatric patients. Hence, over 12 years ago, HCPF set rates for these codes to meet the needs of Health First Colorado members.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the code/modifier/region combinations with the highest utilization for enteral formula.

POS - Enteral Formula Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	B4160	EF PED CALORIC DENSE> /=0.7KC	178.69%	5,346,838	31.45%
2	B4161	EF PED HYDROLYZED/AMINO ACID	120.72%	2,890,897	17.00%
3	B4149	EF BLENDERIZED FOODS	109.38%	2,672,575	15.72%
4	B4152	EF CALORIE DENSE> /=1.5KCAL	142.43%	1,852,887	10.90%
5	B4150	EF COMPLET W/INTACT NUTRIENT	134.61%	1,738,593	10.23%
6	B4153	EF HYDROLYZED/AMINO ACIDS	117.78%	954,791	5.62%
7	B4154	EF SPEC METABOLIC NONINHERIT	210.97%	644,858	3.79%
8	B4158	EF PED COMPLETE INTACT NUT	123.32%	448,721	2.64%
9	B4155	EF INCOMPLETE/MODULAR	329.31%	398,895	2.35%
10	B4102	EF ADULT FLUIDS AND ELECTRO	82.71%	36,047	0.21%

Table 30. Enteral formula top 10 procedure codes by utilization.

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category. The below bubble charts (Figure 6 and Figure 7) indicate the outliers under 60% and above 140% found for enteral formula. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, one outlier with low utilization was excluded from the below 60% chart.

Figure 6 shows that there are four outliers, B4152, B4154, B4155, and B4160, above 140% of the benchmark. Their benchmark ratios range from 142%-329%. B4160 has the highest utilization and repriced amount; its utilization is over 5.3 million allowed units (31% of the total utilization for enteral formula), and its repriced amount is more than \$9.7 million (34% or the total repriced amount for enteral formula). The other outliers have utilization ranging from 1.8 million to 6.4 million allowed units and repriced amounts ranging from \$1.1 million to \$1.2 million.

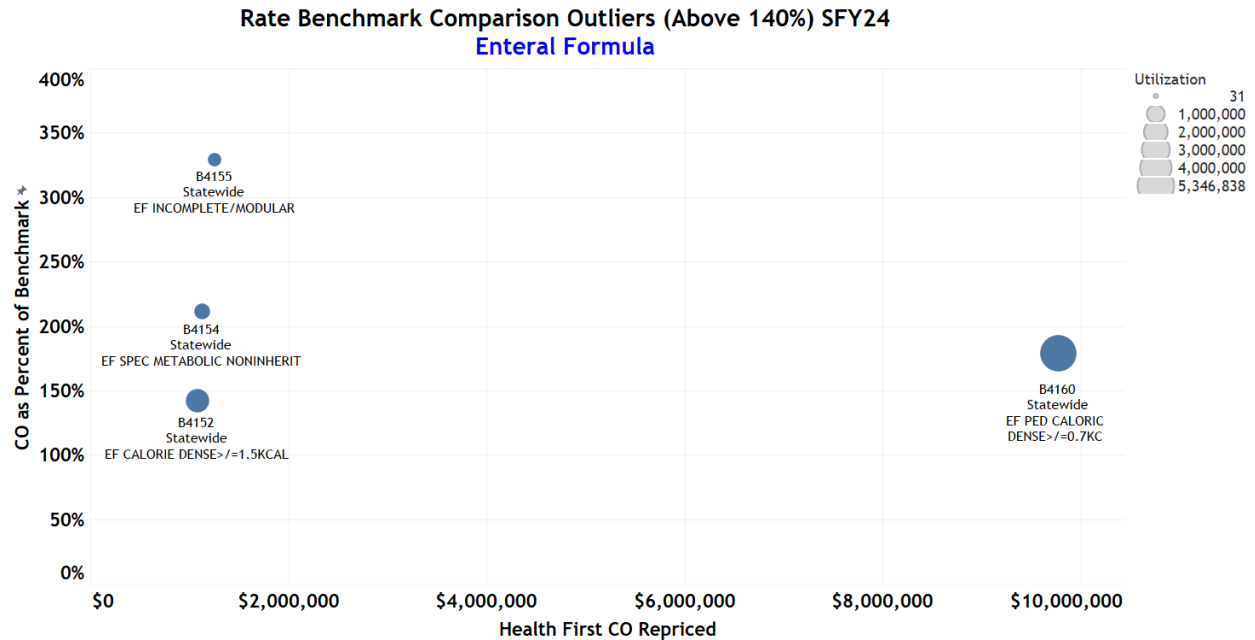


Figure 6. Bubble chart indicating the outliers over 140% for enteral formula.

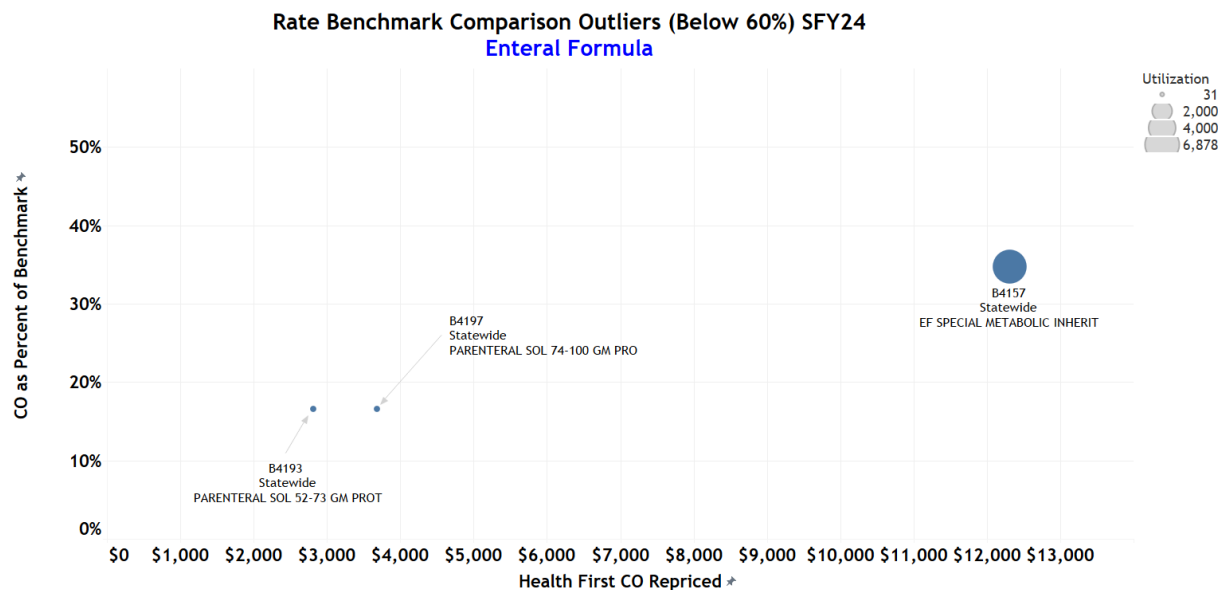


Figure 7. Bubble chart indicating the outliers below 60% for enteral formula.

Figure 7 shows that there are three outliers, B4157, B4193, and B4197, below 60% of the benchmark. Their benchmark ratios range from 16%-34%, their utilization amounts range from 51-6878 allowed units, and their repriced amounts range from \$2,809-\$12,312. B4157 has the highest utilization in this group of outliers, 6878, which accounts for 0.004% of the utilization in this category.

MPRRAC Recommendations

- For the POS - enteral formula category, the MPRRAC recommends no change to the rates. This is because there are many formula products assigned to each code, and while Medicare covers the cost of the standard (low-cost) adult formulas, two-thirds of the Health First Colorado expenditure in this category is for pediatric members who typically require higher cost formulas.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

HCPF Recommendations

- For the POS - enteral formula category, HCPF recommends no change to the rates. This is because there are many formula products assigned to each code, and while Medicare covers the cost of the standard (low-cost) adult formulas, two-thirds of the Health First Colorado expenditure in this category is for pediatric members who typically require higher cost formulas.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Prosthetics, Orthotics, and Disposable Supplies - Other and Disposable Supplies

Service Description

Disposable supplies are healthcare related items that are consumable, disposable, or single-use items for one individual. Supplies are required to address an individual medical disability, illness or injury.

POS - Other and Disposable Supplies Statistics	
Total Adjusted Expenditures SFY 2023-24	\$67,302,598
Total Members Utilizing Services in SFY 2023-24	63,399
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	2.44%
Total Active Providers SFY 2023-24	4,322
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-0.53%

Table 31. Other and disposable supplies total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The other and disposable supplies service grouping has a total of 700 procedure code/modifier/region combinations. The benchmarks for 369 combinations were calculated using the Colorado and benchmark repriced amounts because those combinations had valid SFY 2023-24 utilization data. The benchmarks for 251 combinations were calculated using rate-only comparisons because there was no valid SFY 2023-24 utilization data. In total, 620 of these combinations have a benchmark. The rates for 493 combinations (70.4%) are compared to Medicare, and the rates for 127 combinations (18.2%) are compared to rates from benchmark states. Moreover, 80 combinations (11.4%) are excluded; these exclusions include 36 combinations that do not have a Colorado rate, either because the code is closed (3) or because the code is manually priced (33), and 44 combinations that do not have a valid benchmark.

On average, Colorado Medicaid payments for other and disposable supplies are estimated at 95.74% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

POS - Other and Disposable Supplies Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 10 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$67,302,598	\$70,294,558	95.74%

Table 32. Comparison of Colorado Medicaid other and disposable supplies service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$2,991,960 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate

ratios for other and disposable supplies were 1.33%-320.00%.

Access to Care Analysis

As seen in the other and disposable supplies panel size visual (Appendix B, Figure 37), the average number of utilizers per provider in urban and rural areas was stable. The penetration rate visual (Appendix B, Figure 39) shows that utilization per 1000 members was moderate in much of the state. Finally, the special providers visual (Appendix B, Figure 40) shows that the percent of active providers that served only one Medicaid member remained stable. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the code/modifier/region combinations with the highest utilization for other and disposable supplies.

POS - Other and Disposable Supplies Top 10 Procedure Codes by Utilization						
Rank	Code + Modifier	Service Description	Region	Benchmark Ratio	Utilization	% of Total Utilization
1	A4215	STERILE NEEDLE	Statewide	119.70%	4,058,236	13.39%
2	T4534	YOUTH SIZE PULL-ON	Statewide	134.03%	3,535,036	11.66%
3	T4535	DISPOSABLE LINER/SHIELD/PAD	Statewide	92.13%	3,529,298	11.64%
4	A5120	SKIN BARRIER, WIPE OR SWAB	Statewide	85.31%	1,818,749	6.00%
5	T4526	ADULT SIZE PULL-ON MED	Statewide	104.42%	1,697,834	5.60%
6	T4527	ADULT SIZE PULL-ON LG	Statewide	110.77%	1,676,169	5.53%
7	T4522	ADULT SIZE BRIEF/DIAPER MED	Statewide	109.51%	1,170,971	3.86%
8	T4530	PED SIZE BRIEF/DIAPER LG	Statewide	82.44%	1,035,257	3.42%
9	T4532	PED SIZE PULL-ON LG	Statewide	87.51%	1,010,579	3.33%

10	A6402	STERILE GAUZE <= 16 SQ IN	Statewide	86.14%	756,433	2.50%
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Table 33. Other and disposable supplies top 10 procedure codes by utilization.

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category. The below bubble charts (Figures 8 and 9) indicate the outliers under 60% and above 140% found for other and disposable supplies. Outliers are defined as Colorado Medicaid reimbursement rates that are below 60% or above 140% of the benchmark rate. To protect PHI, 16 outliers with low utilization were excluded from the charts. 14 of these outliers had benchmark ratios below 60% of the benchmark, and two had benchmark ratios above 140%.

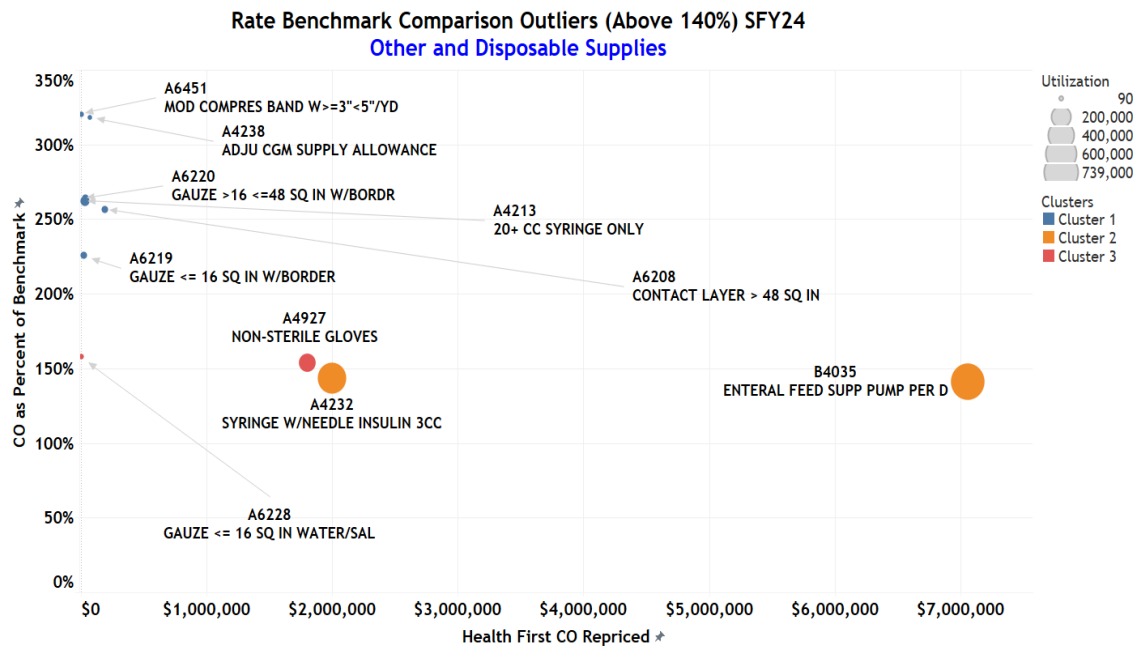


Figure 8. Bubble chart indicating the outliers over 140% for other and disposable supplies.

Figure 8 shows that there are 10 outliers above 140% that are grouped into 3 clusters. The value ranges for each cluster are as follows:

- Cluster 1 contains 6 outliers. Their benchmark ratios range from 226% to 320%, their utilization ranges from 90 to 18,232, and their Colorado repriced amounts range from \$2,524 to \$192,885. This cluster can be characterized as containing outliers with low utilization and Colorado repriced amounts, but high benchmark ratios.

- Cluster 2 contains 2 outliers. Their benchmark ratios range from 141% to 143%, their utilization ranges from 503,688 to 739,000, and their Colorado repriced amounts range from \$2 million to 7.4 million. This cluster can be characterized as containing outliers with high utilization and relatively high Colorado repriced amounts.
- Cluster 3 contains 2 outliers. Their benchmark ratios range from 153% to 158%, their utilization ranges from 512 to 131,552, and their Colorado repriced amounts range from \$1,038 to \$1.8 million. This cluster can be characterized as containing outliers with moderate utilization and Colorado repriced amounts.

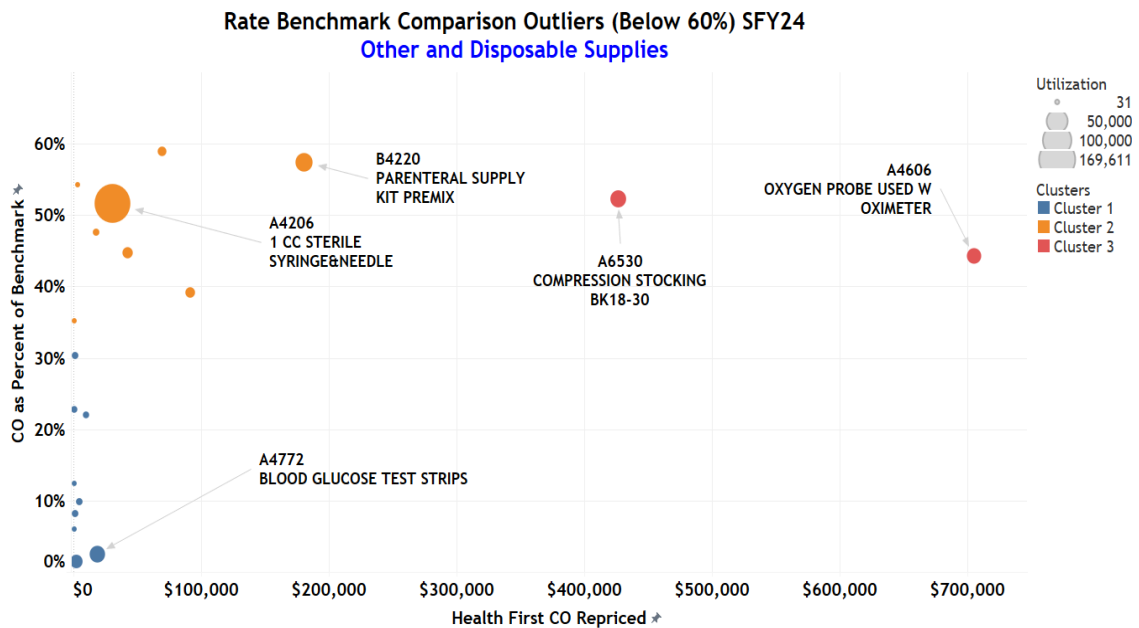


Figure 9. Bubble chart indicating the outliers below 60% for other and disposable supplies

Figure 9 shows that there are 19 outliers below 60% that are grouped into 3 clusters. The value ranges for each cluster are as follows:

- Cluster 1 contains 9 outliers. Their benchmark ratios range from 1% to 30%, their utilization ranges from 46 to 20,180, and their Colorado repriced amounts range from \$39 to \$18,556. This cluster can be characterized as containing outliers with low utilization, low Colorado repriced amounts, and low benchmark ratios.
- Cluster 2 contains XX outliers. Their benchmark ratios range from 35% to 59%, their utilization ranges from 41 to 169,611, and their Colorado repriced amounts range from \$375 to \$180,216. This cluster can be characterized as containing outliers with relatively moderate Colorado repriced amounts and benchmark ratios above 35%.

- Cluster 3 contains 2 outliers. Their benchmark ratios range from 44% to 52%, their utilization ranges from 16,437 to 21,417, and their Colorado repriced amounts range from \$426,232 to \$742,624. This cluster can be characterized as containing outliers with high Colorado repriced amounts and relatively moderate utilization.

MPRRAC Recommendations

- For the POS - other and disposable supplies category, the MPRRAC recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes that are above 80% of the benchmark the same.
- For codes with valid Colorado rates but without benchmark ratios, the MPRRAC recommends an increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$2,894,413 total funds, including \$793,648 General Fund.

HCPF Recommendations

- For POS - Other and Disposable Supplies, HCPF recommends no rate changes at this time due to ongoing federal tariff uncertainty affecting medical supply costs. The Department's 2025 Tariff Survey (Appendix G) found that 53% of respondents reported increased costs for equipment and disposable medical supplies—such as gloves, cotton swabs, and needles—linked to federal tariffs. However, with national trade policies still under review and change, including pending Section 232 investigations into medical products, maintaining current rates is the most prudent approach until federal guidance and market impacts become clearer¹¹.
- For codes with valid Colorado rates but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

¹¹ MedTech Dive. (2025, October 9). *Section 232 investigation creates uncertainty for medtech tariffs*. Retrieved from <https://www.medtechdive.com/news/section-232-tariff-uncertainty-medtech/761224/>

Laboratory and Pathology Services

Service Description

Laboratory and pathology services involve microbiological, serological, chemical, hematological, radiobioassay, cytological, immuno-hematological, pathological or other examinations of fluids derived from the body. The purpose of these examinations is to provide information for the diagnosis, prevention or treatment of a disease or to assess a medical condition.

Laboratory and Pathology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$159,181,669
Total Members Utilizing Services in SFY 2023-24	431,313
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-9.89%
Total Active Providers SFY 2023-24	7,263
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	2.82%

Table 34. Laboratory and pathology total expenditure and utilization data (SFY 2023-24).

Benchmark Rationale

The rates for laboratory and pathology services were compared to Medicare and the rates from 7 benchmark states: Arizona, California, Nebraska, Nevada, Oklahoma, Oregon, and Utah. These states were chosen as benchmarks for the rate comparison analysis because they collectively cover many of the same laboratory and pathology services and have comparable covered populations to Colorado. Additionally, most of the benchmark states are geographically close to Colorado and share provider operating groups and networks. These states were also identified as appropriate benchmarks in previous years of the rate review process and have not significantly altered their payment levels or Medicaid program reimbursement policies. When comparing procedure code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definitions. This leads to inconsistencies in the number of benchmark states available for different codes. For more information on the benchmark states used for a particular code, please see Appendix D.

Rate Comparison Analysis

The laboratory and pathology service grouping has a total of 1,566 procedure code/modifier combinations. The benchmarks for 1072 combinations were calculated using the Colorado and benchmark repriced amounts because those combinations had valid SFY 2023-24 utilization data. The benchmarks for 484 combinations were

calculated using rate-only comparisons because there was no valid SFY 2023-24 utilization data. In total, 1556 of these combinations have a benchmark. The rates for 1,521 combinations (97.1%) were compared to Medicare, and the rates for 35 combinations (2.2%) were compared to rates from benchmark states. Moreover, 10 combinations (0.6%) were excluded; these exclusions included 2 combinations that do not have Colorado rates because the codes were closed prior to the 2025 MPRRAC review and 8 combinations without valid benchmarks.

On average, Colorado Medicaid payments for laboratory and pathology services are estimated at 93.34% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Laboratory and Pathology Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 7 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$159,181,669	\$170,536,743	93.34%

Table 35. Comparison of Colorado Medicaid laboratory and pathology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$11,355,074 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for laboratory and pathology were 8.67%-274.60%.

Access to Care Analysis

As seen in the laboratory and pathology panel size visual (Appendix B, Figure 41), the average number of utilizers in urban regions had a downward trend. The special providers visual (Appendix B, Figure 44) shows that the percentage of active providers that served only one Medicaid member remained stable. Finally, the drive time analysis (Appendix B, Figure 45) shows that drive times were relatively low statewide. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

A stakeholder from GeneDx reached out to inquire about Whole Exome Sequencing (81415/81416) and Whole Genome Testing (81425/81426) codes. Our team was able to connect this stakeholder with the policy specialist to begin the benefit determination process for codes 81415 and 81416. Codes 81425 and 81426 are already on the Clinical Diagnostic Laboratory fee schedule and are under review this year.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure codes with the highest utilization for laboratory and pathology.

Laboratory and Pathology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	87798	DETECT AGENT NOS DNA AMP	100.00%	239,251	5.78%
2	80307	DRUG TEST PRSMV CHEM ANALYZR	81.59%	177,346	4.28%
3	G0483	DRUG TEST DEF 22+ CLASSES	85.90%	151,248	3.65%
4	83036	HEMOGLOBIN GLYCOSYLATED A1C	100.00%	137,330	3.32%
5	80061	LIPID PANEL	100.00%	127,472	3.08%
6	85025	COMPLETE CBC W/AUTO DIFF WBC	100.00%	14,570	2.77%
7	80053	COMPREHEN METABOLIC PANEL	100.00%	107,242	2.59%
8	87591	N.GONORRHOEAE DNA AMP PROB	100.00%	89,975	2.17%
9	87491	CHLMYD TRACH DNA AMP PROBE	100.00%	89,724	2.17%
10	80305	DRUG TEST PRSMV DIR OPT OBS	100.00%	81,402	1.97%

Table 36. Laboratory and pathology top 10 procedure codes by utilization.

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category. The below bubble chart indicates the outliers under 60% or above 140% found for laboratory and pathology. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, nine outliers with low utilization were excluded from the chart. Seven of these exclusions were outliers with benchmark ratios below 60% and two were outliers with benchmark ratios above 140% of the benchmark. There were no other outliers with valid utilization and benchmark ratios above 140% in this service category.

In Figure 10, there are four outliers with repriced amounts and benchmark ratios that are under 60% of the benchmark. Procedure code 36415 has the highest repriced amount at \$182,834 and the highest utilization at 61,139 allowed units. Its benchmark ratio is 43%. The other three outliers, 81194, 85097, and P9612, have benchmark ratios that range from 34%-58%, repriced amounts that range from \$91-\$28,482, and utilization amounts that range from 30-717 allowed units.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Laboratory and Pathology Services

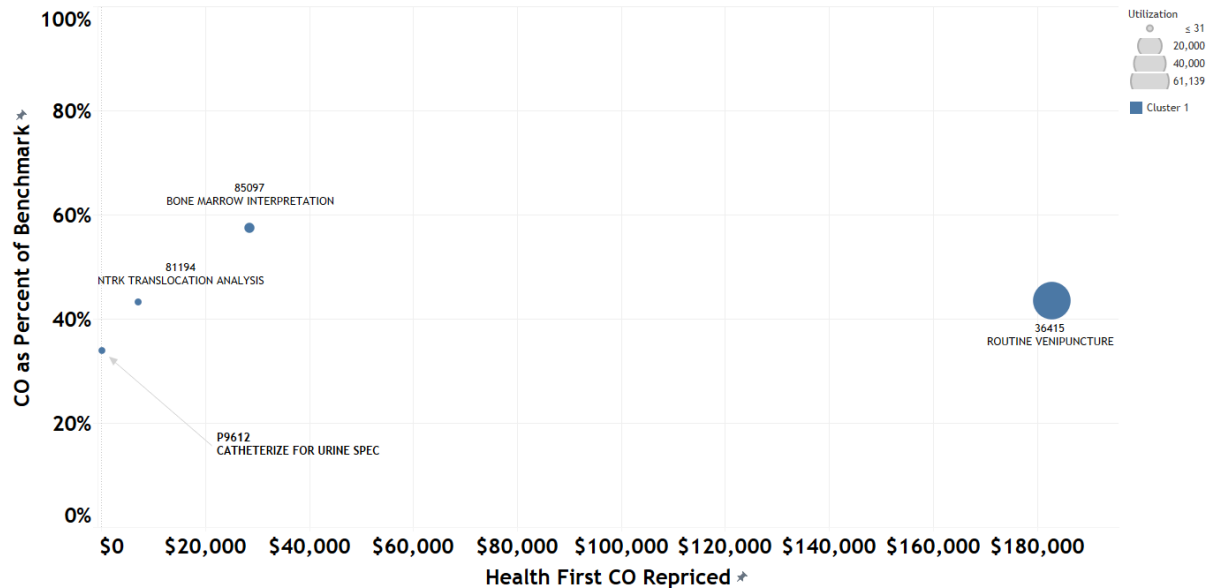


Figure 10. Bubble chart indicating the outliers below 60% and over 140% for laboratory and pathology.

MPRRAC Recommendations

- For laboratory and pathology services, the MPRRAC recommends increasing the rates for codes with valid Colorado rates but without benchmark ratios by 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$0 total funds, including \$0 General Fund, because there was no valid SFY 2023-24 utilization for the codes with valid Colorado rates but without benchmark ratios.
- Moreover, the MPRRAC recommends that HCPF adds coverage for exome sequencing codes 81415 and 81416 and to set their rates at 80% of the Medicare benchmark. To understand the fiscal impact of adding coverage of these codes, they would need to undergo HCPF's Benefit Determination Process.

Procedure Code	Description	January 2025 Medicare Rate	MPRRAC Recommended Rate
81415	Exome sequence analysis	\$4,780	\$3,824
81416	Exome sequence analysis	\$12,000	\$9,600

Table 37. MPRRAC proposed rates for exome sequencing codes 81415 and 81416.

HCPF Recommendations

- For laboratory and pathology services, HCPF recommends no change to the rates¹² due to budget constraints.
- For codes with valid Colorado rates but without benchmark ratios, HCPF recommends no change due to budget constraints.
- HCPF does not recommend conducting the Benefit Determination Process for codes 81415 and 81416. Supported by [89% of HCPF's annual webinar attendees](#), the department is making strategic decisions guided by the [Medicaid Sustainability Framework](#). As part of this approach, adding coverage for new codes does not align with a focus on controlling cost trends and exercising caution when allocating resources. This caution allows the state to protect core services and avoid more severe cuts in the future.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

¹² In the Laboratory and Pathology service category, currently 1309 codes are subject to the [CDL-UPL adjustment](#).

Outpatient Physical Therapy (PT), Occupational Therapy (OT), & Speech Therapy (ST) Services - Overview

Service Description

Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Therapy (ST) are rehabilitative services that focus on different aspects of a patient's functionality and well-being. These therapies are provided by licensed professionals. Treatment plans typically include specific, functionally-based goals, proposed interventions, and the estimated duration and frequency of services.

Benchmark Rationale

The rates for Outpatient PT, OT & ST Services were compared to Medicare and the rates from 8 benchmark states: Arizona, California, Maine, Michigan, Minnesota, North Dakota, Oregon, and South Carolina. These states were chosen as benchmarks for the rate comparison analysis because they have comparable benefit packages and covered populations to Colorado.

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

For more information on the benchmark states used for a particular code, please see Appendix D.

Outpatient Physical Therapy (PT) Services

Service Description

Outpatient Physical Therapy (PT) is a healthcare service provided by licensed professionals called physical therapists. Physical therapists diagnose and treat patients with medical problems or injuries that limit their mobility and daily functioning. PT aims to improve a patient's ability to move, function, and manage pain through various techniques and interventions.

A summary of the statistics for Outpatient Physical Therapy (PT) is provided below:

Outpatient Physical Therapy (PT) Statistics	
Total Adjusted Expenditures SFY 2023-24	\$40,795,510
Total Members Utilizing Services in SFY 2023-24	30,183
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	5.48%
Total Active Providers SFY 2023-24	1,761
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	7.84%

Table 38. Outpatient Physical Therapy (PT) total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Outpatient Physical Therapy (PT) has 51 procedure code/modifier combinations. The rates for 41 of them (80.39%) were compared to Medicare, while the rates for 8 codes (15.69%) were compared to rates from other states:

Outpatient Physical Therapy (PT) Benchmark States	
Procedure Code	Benchmark State
95120	California, Minnesota and North Dakota
95130	Arizona, California, Maine, Michigan and Minnesota

Table 39. Outpatient Physical Therapy (PT) Benchmark States (SFY 2023-24).

Among these 51 codes, 13 of them (16.59%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. There are two codes being excluded due to no benchmark rates. Individual rate ratios for Physical Therapy (PT) were 75.03% - 121.83%.

On average, Colorado Medicaid payments for Physical Therapy (PT) are estimated at 100.85% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Outpatient Physical Therapy (PT) Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 8 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$40,795,510	\$40,450,673	100.85%

Table 40. Comparison of Colorado Medicaid Outpatient Physical Therapy (PT) payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$344,837 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the Physical Therapy (PT) panel size visual (Appendix B, Figure 46), the average number of utilizers per provider in urban areas increased before decreasing. The percentage of active providers that served Medicaid members was 37% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 49) shows that the percent of active providers that served only one Medicaid member remained relatively stable. The telemedicine analysis (Appendix B, Figures 50 & 51) shows that the percentage of individual members that utilized telemedicine services and the percentage of total visits that were delivered through telemedicine decreased. The drive time analysis (Appendix B, Figure 52) shows that drive times were relatively low statewide, with some higher drive times (over an hour) in parts of Eastern and Western Colorado. Finally, Colorado Medicaid had higher per utilizer per month (PUPM) expenditures than most payers and higher per utilizer per year (PUPY) utilization than all payers (Appendix B, Figures 53 & 54). These findings indicate that access to care is stable.

See Appendix B for full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier/region combinations for Physical Therapy (PT).

Outpatient Physical Therapy (PT) Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	97530	THERAPEUTIC ACTIVITIES	97.83%	369,777	30.26%
2	97110	THERAPEUTIC EXERCISES	108.78%	277,910	22.75%
3	97112	NEUROMUSCULAR REEDUCATION	101.95%	271,412	22.21%
4	97140	MANUAL THERAPY 1/> REGIONS	107.47%	166,254	13.61%
5	97150	GROUP THERAPEUTIC PROCEDURES	85.86%	30,786	2.52%
6	97113	AQUATIC THERAPY/EXERCISES	107.27%	18,751	1.53%
7	97533	SENSORY INTEGRATION	91.13%	14,757	1.21%
8	97164	PT RE-EVAL EST PLAN CARE	86.78%	13,552	1.11%
9	97014	ELECTRIC STIMULATION THERAPY	119.82%	11,618	0.95%
10	97162	PT EVAL MOD COMPLEX 30 MIN	86.83%	10,050	0.82%

Table 41. Outpatient Physical Therapy (PT) top 10 procedure codes ranked by utilization

Year-over-Year Reimbursement Rate Trend Analysis

The Physical Therapy (PT) services subcategory has an overall benchmark ratio of 100.85%, indicating that Colorado Medicaid reimbursement exceeds Medicare benchmarks on average. To better understand this high benchmark ratio, HCPF conducted a year-over-year reimbursement rate percentage changes analysis across 41 procedure code and modifier combinations using Medicare for benchmarking. 10 of these 41 codes have a benchmark ratio above 100%, with eight of them showing utilization in SFY 2023-24.

As shown in Figure 11:

- Analysis for these 41 codes shows the biggest impact in the previous four years came from SFY 2021-22, when CO Medicaid rates on average rose 63.93%, then 35.52% the following year. Meanwhile the average Medicare rate has been steadily decreasing at a slight pace (<0.5%), with the exception of 2023-2024, when the rate dropped 3.21%.
- The significant increase in Colorado Medicaid rates from SFY 2021-22 was primarily driven by two codes, likely due to targeted rate adjustments:
 - o 97110: therapeutic exercises (197% increase, current benchmark ratio: 108.8%)
 - o 97112: neuromuscular reeducation (210% increase current benchmark ratio: 102.0%)

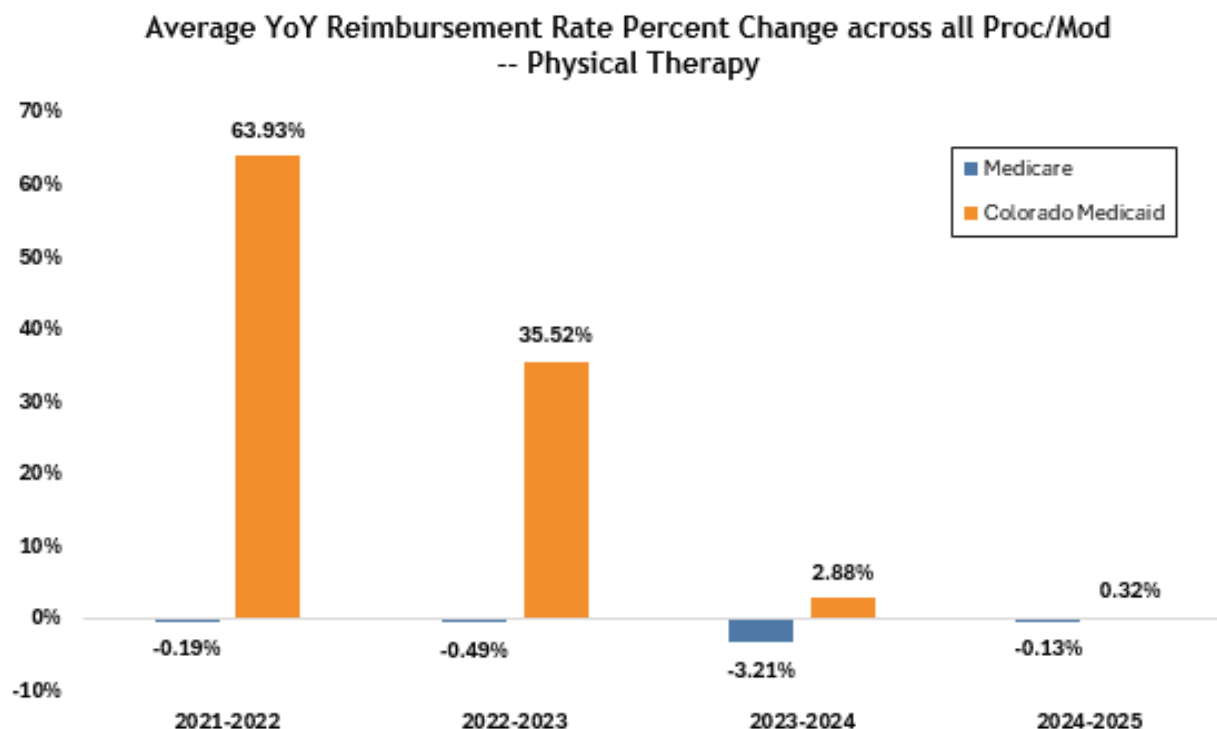


Figure 11. Bar chart indicating the average year-over-year Outpatient Physical Therapy (PT) reimbursement rate percentage changes for Medicare and Colorado Medicaid

Potential Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the Physical Therapy (PT) services subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

We received a list of potential preventive code recommendations from Chris Edmundson, PT, DPT, Co-Chair of Colorado Chapter American Physical Therapy Association (APTA). Initially, the provider recommendation suggested that all physical therapy services be considered preventive, based on their role in reducing downstream medical utilization and associated costs. However, according to the [Centers for Medicare & Medicaid Services \(CMS\)](#), outpatient physical and occupational therapy services are categorized as rehabilitative rather than preventive. Additionally, a review of the [U.S. Preventive Services Task Force \(USPSTF\) A and B ratings](#) found no PT, OT, or ST-related codes listed. As a result, the provider revised the recommendation, narrowing it from all physical therapy codes to a focused list of 12. Given the differing interpretations of what qualifies as “preventive” between the provider and HCPF, we are currently referring to these as “potential preventive codes.”

There are 12 potential preventive codes (23.5% of Outpatient Physical Therapy (PT) codes) in this service grouping. All these 12 potential preventive codes use Medicare for benchmarking. The benchmark ratio range is 85.9% - 108.8%.

As shown in table below, Outpatient Physical Therapy (PT)'s potential preventive codes have a high utilization percentage (over 80%) and account for a large portion of total expenditures (over 80%).

Service SubCategory	Potential Preventive Code Count	Utilization Percentage	CO Repriced Amount Percentage	Overall benchmark Ratio
Outpatient Physical Therapy (PT)	12	81.16%	82.59%	100.27%

Table 42. Outpatient Physical Therapy (PT) preventive codes analysis

MPRRAC Recommendations

- The MPRRAC recommends adjusting the rates for the two highly used codes (97530 and 97533) to 100% of the benchmark rate.
- The MPRRAC recommends for codes with valid Colorado rate but without benchmark rates, a rate increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$363,088 total funds, including \$181,544 General Fund.

HCPF Recommendations

- HCPF recommends increasing the rates for all codes under 95% of the benchmark to 95% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark rates, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$889,235 Total Funds, including -\$444,618 General Fund.

Occupational Therapy (OT) Services

Service Description

Occupational Therapy (OT) is a healthcare service provided by licensed professionals that aims to improve a person's ability to perform daily activities and participate in meaningful occupations. OT supports individuals whose physical, mental, or developmental conditions impact their ability to engage in everyday tasks.

A summary of the statistics for the Outpatient Occupational Therapy (OT) subcategory is provided below:

Outpatient Occupational Therapy (OT) Statistics	
Total Adjusted Expenditures SFY 2023-24	\$34,539,705
Total Members Utilizing Services in SFY 2023-24	12,788
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	6.32%
Total Active Providers SFY 2023-24	754
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	2.59%

Table 43. Outpatient Occupational Therapy (OT) total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Outpatient Occupational Therapy (OT) has 49 procedure code/modifier combinations. The rates for 40 of them (81.63%) were compared to Medicare, while the rates for 8 codes (16.33%) were compared to rates from other states:

Outpatient Occupational Therapy (OT) Benchmark States	
Procedure Code	Benchmark State
97014	Arizona, California, Maine, Michigan and Minnesota
97602	Maine and Minnesota
L3764	Arizona, California, Minnesota, North Dakota and Oregon
L3900	Arizona, California, Minnesota and Oregon
L3919	Arizona, California, Maine, Minnesota and Oregon
Q4040	Arizona, Michigan, Minnesota, North Dakota and Oregon
Q4048	Arizona, Michigan, Minnesota, North Dakota and Oregon
97010	California, Minnesota and North Dakota

Table 44. Outpatient Occupational Therapy (OT) Benchmark States (SFY 2023-24).

Among these 49 codes, 14 of them (28.57%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. There is one code

being excluded due to no benchmark rates. Individual rate ratios for Outpatient Occupational Therapy (OT) were 75.03% - 121.85%.

On average, Colorado Medicaid payments for Outpatient Occupational Therapy (OT) are estimated at 96.57% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below:

Outpatient Occupational Therapy (OT) Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 8 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$34,539,705	\$35,766,928	96.57%

Table 45. Comparison of Colorado Medicaid Outpatient Occupational Therapy (OT) payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,227,223 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the Outpatient OT panel size visual (Appendix B, Figure 55), the average number of utilizers per provider in urban and rural areas remained stable. The percentage of active providers that served Medicaid members was 51% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 58) shows that the percent of active providers that served only one Medicaid member remained relatively stable. The telemedicine analysis (Appendix B, Figures 59 & 60) shows that the percentage of individual members that utilized telemedicine services and the percentage of total visits that were delivered through telemedicine decreased. The drive time analysis (Appendix B, Figure 61) shows that drive times were relatively low statewide, although higher drive times (over an hour) were noted in parts of Eastern and Western Colorado. Finally, Colorado Medicaid had higher per utilizer per month (PUPM) expenditures and per utilizer per year (PUPY) utilization than other payers (Appendix B, Figures 62 & 63). These findings indicate that access to care is relatively stable, although longer distances to providers in some counties may impact access.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier/region combinations for Outpatient Occupational Therapy (OT).

Outpatient Occupational Therapy (OT) Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	97530	THERAPEUTIC ACTIVITIES	97.80%	712,744	76.05%
2	97533	SENSORY INTEGRATION	91.10%	109,526	11.69%
3	97110	THERAPEUTIC EXERCISES	108.79%	41,565	4.43%
4	97112	NEUROMUSCULAR REEDUCATION	101.94%	28,183	3.01%
5	97535	SELF CARE MNGMENT TRAINING	86.94%	13,311	1.42%
6	97113	AQUATIC THERAPY/EXERCISES	107.38%	8,017	0.86%
7	97166	OT EVAL MOD COMPLEX 45 MIN	85.13%	6,390	0.68%
8	97140	MANUAL THERAPY 1/> REGIONS	107.61%	5,599	0.60%
9	97168	OT RE-EVAL EST PLAN CARE	84.62%	2,834	0.30%
10	97165	OT EVAL LOW COMPLEX 30 MIN	84.95%	1,289	0.14%

Table 46. Outpatient Occupational Therapy (OT) top 10 procedure codes ranked by utilization

Potential Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the Outpatient Occupational Therapy (OT) services subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

We received a set of potential preventive code recommendations from Molly Hahn-Floyd, OTD, OTR/L, President of Occupational Therapy Association of Colorado (OTAC). However, HCPF believes that the majority of these codes are more appropriately categorized as treatment rather than preventive services. According to the [Centers for Medicare & Medicaid Services \(CMS\)](#), outpatient physical and occupational therapy services are categorized as rehabilitative rather than preventive. Additionally, a review of the [U.S. Preventive Services Task Force \(USPSTF\) A and B ratings](#) found no PT, OT, or ST-related codes listed. Due to differing interpretations between the provider and HCPF regarding the definition of

"preventive," we are currently referring to these as potential preventive codes pending further review and clarification.

There are 14 potential preventive codes (29.2% of total OT codes) in this service grouping, all 14 potential preventive codes use Medicare for benchmarking. The benchmark ratio range is 84.6% - 121.9%.

As shown in table below, Outpatient Occupational Therapy (OT)'s potential preventive codes have a high utilization percentage (over 90%), and account for a large portion of total expenditure (over 90%).

Service SubCategory	Potential Preventive Code Count	Utilization Percentage	CO Repriced Amount Percentage	Overall benchmark Ratio
Occupational Therapy (OT)	14	90.56%	91.61%	95.87%

Table 47. Outpatient Occupational Therapy (OT) potential preventive codes analysis

MPRRAC Recommendations

- The MPRRAC recommends adjusting the rates for the two highly used codes (97530 and 97533) to 100% of the benchmark rate.
- The MPRRAC recommends for codes with valid Colorado rate but without benchmark rates, a rate increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,150,651 total funds, including \$575,326 General Fund, when extrapolated to a full year.

HCPF Recommendations

- HCPF recommends increasing the rates for all codes under 95% of the benchmark to 95% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark rates, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$257,450 Total Funds, including \$128,725 General Fund.

Speech-Language Therapy (ST) Services

Service Description

Speech-Language Therapy (ST) is a specialized healthcare service provided by licensed speech-language pathologists (SLPs) to assess, diagnose, and treat communication and swallowing disorders in individuals of all ages. ST aims to improve a person's ability to communicate effectively and address challenges related to speech, language, voice, fluency, and swallowing.

A summary of the statistics for the Outpatient Speech-Language Therapy (ST) subcategory is provided below:

Outpatient Speech-Language Therapy (ST) Statistics	
Total Adjusted Expenditures SFY 2023-24	\$27,150,581
Total Members Utilizing Services in SFY 2023-24	12,937
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	7.52%
Total Active Providers SFY 2023-24	752
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	7.74%

Table 48. Outpatient Speech-Language Therapy (ST) total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Outpatient Speech-Language Therapy (ST) has 26 procedure code/modifier combinations. The rates for 21 of them (80.77%) were compared to Medicare, while the rates for 5 codes (19.23%) were compared to rates from other states:

Outpatient Speech-Language Therapy (ST) Benchmark States	
Procedure Code	Benchmark State
92507+GT	Arizona, California, Michigan, Minnesota, North Dakota, Oregon and South Carolina
92605	Arizona, California, Minnesota and North Dakota
92606	Arizona, California, Minnesota, North Dakota and South Carolina
V5011	California, Minnesota and Oregon
Q3014	California, North Dakota and Oregon

Table 49. Outpatient Speech-Language Therapy (ST) Benchmark States (SFY 2023-24).

Among these 26 codes, 2 of them (7.69%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for Speech-Language Therapy (ST) were 34.24% - 235.53%.

On average, Colorado Medicaid payments for Speech-Language Therapy (ST) are estimated at 93.63% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below:

Outpatient Speech-Language Therapy (ST) Repriced Benchmark Comparison		
Colorado Repriced	Medicare and 8 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$27,150,581	\$28,996,298	93.63%

Table 50. Comparison of Colorado Medicaid Outpatient Speech-Language Therapy (ST) payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,845,717 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the Speech-Language Therapy (ST) panel size visual (Appendix B, Figure 64), the average number of utilizers per provider in urban areas increased and then decreased. The percentage of active providers that served Medicaid members was 61% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 67) shows that the percent of active providers that served only one Medicaid member remained relatively stable. The telemedicine analysis (Appendix B, Figures 68 & 69) shows that the percentage of individual members that utilized telemedicine services and the percentage of total visits that were delivered through telemedicine decreased. The drive time analysis (Appendix B, Figure 70) shows that drive times were higher (over an hour) in parts of Eastern and Western Colorado. Finally, Colorado Medicaid had higher per utilizer per month (PUPM) expenditures and per utilizer per year (PUPY) utilization than other payers (Appendix B, Figures 71 & 72). These findings indicate that longer distances to providers may impact access for residents of some counties if in-person services are required.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier/region combinations for Speech-Language Therapy (ST).

Outpatient Speech-Language Therapy (ST) Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	92507	SPEECH/HEARING THERAPY	93.40%	262,621	70.02%
2	92609	USE OF SPEECH DEVICE SERVICE	86.91%	37,689	10.05%
3	92507+GT	SPEECH/HEARING THERAPY	150.25%	19,318	5.15%
4	92508	SPEECH/HEARING THERAPY	85.46%	12,981	3.46%
5	92526	ORAL FUNCTION THERAPY	86.76%	12,422	3.31%
6	92523	SPEECH SOUND LANG COMPREHEN	86.12%	11,249	3.00%
7	97130	THER IVNTJ EA ADDL 15 MIN	121.83%	7,432	1.98%
8	97129	THER IVNTJ 1ST 15 MIN	121.93%	4,405	1.17%
9	96112	DEVEL TST PHYS/QHP 1ST HR	86.55%	2,088	0.56%
10	92524	BEHAVRAL QUALIT ANALYS VOICE	87.28%	957	0.26%

Table 51. Outpatient Speech-Language Therapy (ST) top 10 procedure codes ranked by utilization

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as rates in CO that are below 60% or above 140% of the benchmark. The bubble chart below indicates that there are two procedure code/modifier combinations with rates above 140% of the benchmark rate. To protect PHI, 2 outliers with low utilization were excluded from the chart. Additionally, no outliers with a benchmark ratio below 60% were identified.

Figure 12 shows that there are two procedure code/modifier combinations, 92507+GT and V5011, with valid SFY 2023-24 utilization that are above 140% of the benchmark. 92507+GT had a utilization of 19,318 (5.15% of the total utilization in the category) with a Health First Colorado repriced amount of \$1,455,799 (5.36% of the total Health First Colorado repriced amount in the category). V5011 had a small utilization of 196 with a Health First Colorado repriced amount of \$232.

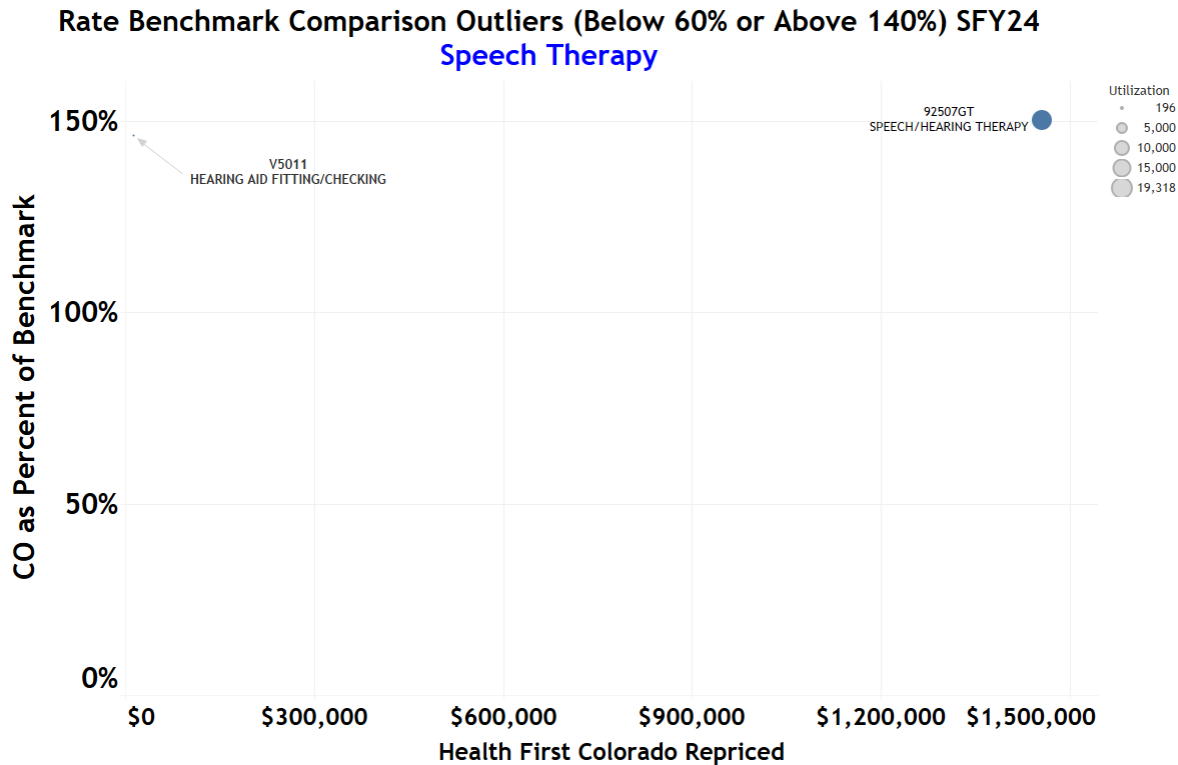


Figure 12. Bubble Chart indicating the outliers below 60% and over 140% found for Outpatient Speech-Language Therapy (ST)

Potential Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the Speech-Language Therapy (ST) subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

We received a set of potential preventive code recommendations from Jessi Hogan, M.S., CCC-SLP, President of Colorado Speech-Language-Hearing Association (CSHA). HCPF, however, believe that the majority of these codes are more appropriately categorized as early intervention, rehabilitation, and treatment, rather than preventive services. Additionally, a review of the [U.S. Preventive Services Task Force \(USPSTF\) A and B ratings](#) found no PT, OT, or ST-related codes listed. Due to differing interpretations between the provider and HCPF regarding the definition of "preventive," we are currently referring to these as potential preventive codes pending further review and clarification.

There are 7 potential preventive codes (29.2% of total ST codes) in this service grouping. All 7 potential preventive codes use Medicare for benchmarking. The benchmark ratio range is 85.5% - 93.4%.

As shown in table below, Speech-Language Therapy (ST)'s potential preventive codes have a high utilization percentage (over 90%), and account for a large portion of total expenditure (over 90%).

Service SubCategory	Potential Preventive Code Count	Utilization Percentage	CO Repriced Amount Percentage	Overall benchmark Ratio
Speech-Language Therapy (ST)	7	90.30%	91.82%	91.45%

Table 52. Outpatient Speech-Language Therapy (ST) preventive codes analysis

Rate Alignment Issue Analysis

At the March 2025 public meeting, two rate alignment issues were brought up for MPRRAC committee's attention.

The first issue was regarding 92507 (speech/hearing therapy) about different reimbursement rates for outpatient ST (\$72.01) and home health ST (\$155.48). We believe that because outpatient and home health services serve different populations and are subject to different regulations and requirements, their rates cannot be compared directly without introducing confounding factors.

The second issue was mentioned for codes with a GT modifier which were \$5 more than the same codes without GT modifier. We are open to discuss this with the provider community and see if any adjustments need to be made.

MPRRAC Recommendations

- The MPRRAC recommends adjusting the rates for the four highly used codes (92507, 92609, 92508 and 92526) to 100% of the benchmark rate.
- The MPRRAC recommends no premium for GT telehealth modifiers, meaning the rate will be the same with code without GT telehealth modifiers.
- The MPRRAC recommends HCPF to look into and evaluate rates between Home Health and outpatient Speech Therapy, acknowledging that home health rates account for drive time and mileage to and from, but should determine whether magnitude of difference exceeds what would be appropriate reflecting on rate difference.

- The MPRRAC recommends HCPF to review the reimbursement rate structures for PT/OT and ST to ensure parity. For example, some PT/OT service codes are billed in 15-minute increments, while equivalent ST service codes are limited to a single unit per session, which can result in higher reimbursement for PT/OT if the session runs long.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,950,074 total funds, including \$975,037 General Fund, when extrapolated to a full year.

HCPF Recommendations

- HCPF recommends increasing the rates for all codes under 95% of the benchmark to 95% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark.
- HCPF agrees to evaluate Home Health and outpatient Speech Therapy rates, accounting for drive time and mileage in Home Health, to determine whether the rate differences are appropriate.
- HCPF agrees to evaluate PT/OT and ST rate structures, specifically considering that PT/OT codes are billed in 15-minute increments while ST codes are limited to a single unit per session, to determine whether reimbursement levels are equitable.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$458,191 Total Funds, including \$229,096 General Fund.

Policy Justification

The Department acknowledges the MPRRAC committee's recommendation to re-evaluate telehealth premiums for parity. Currently, the GT modifier provides an additional \$5 reimbursement for codes listed in the Telemedicine Billing Manual, and the telehealth transmission fee is outlined in the State Plan Amendment (SPA, Appendix F1). While the Department does not object to the removal of this add-on, any change would require a collaborative process with stakeholders and formal amendments to the SPA. Given these considerations, the Department recommends further stakeholder engagement prior to implementing changes to ensure alignment with policy requirements and provider needs.

The Department acknowledges MPRRAC's two policy-related recommendations and has agreed to investigate Home Health and outpatient Speech Therapy rates, as well as evaluate the structural differences between PT/OT and ST reimbursement.

Specialty Care Services

Service Description

Specialty care services include skin substitutes and eConsult codes. Skin substitutes are advanced wound care products designed to replace or regenerate damaged skin. Skin substitute products are categorized and reimbursed based on their composition: allogenic acellular, allogenic cellular, xenogenic and injections. eConsult is defined as an asynchronous dialogue initiated by a treating practitioner seeking a consulting practitioner's expert opinion without a face-to-face member encounter with the consulting practitioner. Providers can utilize HCPF's eConsult platform, [Colorado Medicaid eConsult](#), or a third-party eConsult platform that meets HCPF's criteria.

Specialty Care Services Statistics	
Total Adjusted Expenditures SFY 2023-24	\$45,409
Total Members Utilizing Services in SFY 2023-24	*13
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-22.22%
Total Active Providers SFY 2023-24	12
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-7.69%

Table 53. Specialty care services total expenditure and utilization data (SFY 2023-24).

Benchmark Rationale

In the specialty care services category, rates for eConsult codes were compared to Medicare and the rates for skin substitutes were compared to the rates from 9 benchmark states: Arkansas, Georgia, Illinois, Maine, Nevada, New Mexico, Oklahoma, Oregon, and Washington. These states were chosen because they use a FFS model to cover skin substitutes. The service definitions and program requirements for these skin substitute codes are comparable to those covered by Health First Colorado.

Rate Comparison Analysis

There were two eConsult codes in this category. These codes were a new benefit as of February 1, 2024; hence, there was not sufficient utilization data, so a rate-only comparison, with Medicare as the benchmark, was performed.

Health First Colorado reimburses for skin substitutes based on their composition. There are four skin substitute types: allogenic acellular, allogenic cellular, xenogenic, and injections. Medicare is not a valid comparator for these services, so benchmark states were used. Due to the different coverage methods used in different states, HCPF mapped the other state rates into the four defined categories to obtain benchmark rates. The process is as follows:

1. Obtain the benchmark state rates
2. Include codes with more than 1 benchmark state rate

¹³ To protect PHI, the number of members that utilized this service in SFY 2023-24 was omitted.

3. Average the included rates within each skin substitute group for each state
4. Apply the cost of living adjustment relative to Colorado
5. Find the average rate across the benchmark states for each skin substitute group

For more information on how the benchmark rates for skin substitutes were calculated, see appendix D.2.

On average, Colorado Medicaid payments for specialty care services are estimated to be at 81.09% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Specialty Care Repriced Benchmark Comparison		
Colorado Repriced	9 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$45,409	\$55,997	81.09%

Table 54. Comparison of Colorado Medicaid specialty care services payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$10,588 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for specialty care services were 30.24%-104.69%.

Access to Care Analysis

As seen in the specialty care services panel size visual (Appendix B, Figure 73), the average number of utilizers per provider in urban and rural areas was stable. The percentage of active providers that served Medicaid members was 18% in SFY 2023-24. The drive time analysis (Appendix B, Figure 76) shows that much of the state had relatively high drive times (over an hour). Additionally, Colorado Medicaid had much lower per utilizer per month (PUPM) expenditures but higher per utilizer per year (PUPY) utilization than commercial payers (Appendix B, Figures 77 & 78). While a low utilized service, these findings indicate that access to care may be impacted by low provider participation, longer driving distances, and low reimbursements.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

A stakeholder from McGuireWoods Consulting LLC reached out and suggested Arizona and Georgia as benchmark states. After researching the reimbursement methodologies for skin substitutes in these states, it was found that Arizona is not appropriate to use as a benchmark for this service because Arizona does not have FFS rates for skin

substitutes; however, Georgia was incorporated as a benchmark state because it covers similar skin substitute codes using a FFS model.

See Appendix I for stakeholder feedback.

Additional Research

Utilization Analysis

The table below shows the number of procedure codes in each skin substitute category, the benchmark ratios, and the utilization statistics. Since there was no valid SFY 2023-24 utilization for any of the codes in the injections skin substitute category, its benchmark ratio is based on a rate-only comparison.

Skin Substitute Groups by Utilization					
Code Count	Skin Sub Group	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
7	Allogenic Cellular	Product is derived from human cells and contains whole and/or living cells	81.17%	1,034	86.02%
27	Allogenic Acellular	Product is derived from human cells and does not contain living cells	82.96%	130	10.82%
20	Xenogenic	Product is derived from a non-human species	52.50%	38	3.16%
3	Injection	Injectable products	30.24% ¹⁴	0	0

Table 55. Skin substitute groups by utilization.

MPRRAC Recommendations

- For specialty care services, the MPRRAC recommends increasing the rates for all codes and skin substitute groups that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes and skin substitute groups that are above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$295 total funds, including \$81 General Fund.

¹⁴ There was no valid SFY 2023-24 utilization for the three procedure codes that fall into the injectable skin substitute category; hence, a rate-only comparison was used to calculate the benchmark ratio.

HCPF Recommendations

- For specialty care services, HCPF recommends increasing the rates for all codes and skin substitute groups that are under 80% of the benchmark ratio to 80% of the benchmark and to keep the rates for all codes and skin substitute groups that are above 80% of the benchmark the same.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$295 total funds, including \$81 General Fund.

Early Intervention (EI) Targeted Case Management (TCM)

Service Description

EI-TCM services provide developmental support to children 0-3 who have a significant developmental delay or a condition that has a high probability of resulting in a developmental delay. Services are provided through early intervention service brokers and may include:

- Locating, coordinating, and monitoring developmental disabilities services.
- Coordinating with other non-developmental disabilities funded services to ensure non-duplication of services.
- Monitoring the effective provision of services across multiple funding sources.

A summary of the statistics for EI-TCM services is provided below:

EI-TCM Statistics	
Total Adjusted Expenditures SFY 2023-24	\$5,111,573
Total Members Utilizing Services in SFY 2023-24	7,975
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.66%
Total Active Providers SFY 2023-24	108
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.93%

Table 56. EI-TCM total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Benchmark State Rationale

Louisiana, Maine, Missouri, and North Carolina were selected as benchmark states. All four states, like Colorado, have FFS case management rates and have a state run program which provides these services for children. North Carolina and Missouri were the only states used as benchmarks for assessment code T1026+TL. This is because, like Colorado, these two states have a separate rate for initial assessments used to determine the level of care required to meet the child's needs.

EI-TCM Benchmark States	
Procedure Code	Benchmark State
T1017 + TL	Louisiana, Maine, Missouri, North Carolina
T1026 + TL	Missouri, North Carolina

Table 57. Targeted case management - case management benchmark states (SFY 2023-24).

See Appendix D.3 for a detailed explanation of how benchmark rates were calculated.

Of the two codes analyzed in this service grouping, one code was compared to four states and one code was compared to two states, both codes had valid utilization. On average, Colorado Medicaid payments for EI-TCM are estimated at 73.56% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

EI-TCM Repriced Benchmark Comparison		
Colorado Repriced	4 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$5,111,573	\$6,948,604	73.56%

Table 58. Comparison of Colorado Medicaid EI-TCM service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,837,031 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24. Individual rate ratios for EI-TCM were 68.91%-101.60%.

Access to Care Analysis

As seen in the EI-TCM panel size visual (Appendix B, Figure 79), the average number of utilizers per provider in urban areas had a decreasing trend. The percentage of active providers that served Medicaid members was 97% in SFY 2023-24. The telemedicine analysis (Appendix B, Figures 82 & 83) shows that the percentage of individual members that utilized telemedicine services and the percentage of total visits that were delivered through telemedicine increased. Finally, the drive time analysis (Appendix B, Figure 84) shows that some parts of the state had relatively high drive times (over an hour). These findings suggest that longer distances may impact accessibility if members must travel to a facility to receive services.

See Appendix B for the full access to care analysis.

Stakeholder Feedback

We collaborated with policy experts at the Colorado Department of Early Childhood (CDEC) to choose benchmark states that offered similar EI-TCM services to Colorado.

See Appendix I for Stakeholder Feedback.

MPRRAC Recommendations

- EI-TCM services, the MPRRAC recommends increasing the rate for T1017 TL to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$660,902 total funds, including \$330,451 General Fund.

HCPF Recommendations

- For EI-TCM services, HCPF recommends no changes to the rates due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Targeted Case Management (TCM) - Overview

Service Description

TCM services are services that help members access necessary long term services and supports and receive the benefits that they are entitled to. TCM services can save Medicaid programs money by ensuring that qualifying members are receiving appropriate home and community based services so that members do not need more expensive institutional services in the future.¹⁵ Health First Colorado provides members with two subcategories of TCM services, case management and transition coordination. Case management services are available to any members enrolled in a Home and Community-Based Services (HCBS) waiver program and Community First Choice (CFC) state plan benefit. Transition coordination is a specific transitional service that supports members as they move from a congregate living setting to a community based living setting.

¹⁵ 1. Angelo P. Giardino, "Case Management," *StatPearls [Internet]*., August 14, 2023, <https://www.ncbi.nlm.nih.gov/books/NBK562214/>.

Targeted Case Management - Case Management

Case Management Redesign

Starting July 1st, 2024, Colorado's case management system was redesigned so that case management activities are paid the same rates across all HCBS waiver and Long Term Services and Supports (LTSS) programs. It requires that Targeted Case Management (TCM) services are rendered exclusively by Case Management Agencies (CMAs) as FFS and that CMAs accept members from LTSS programs. Implemented July 1st, 2024, these changes were made so that members receive more equitable and member-focused care.

Service Description

Case management services ensure that a member is receiving services as outlined by the Centers for Medicare & Medicaid Services in their Person Centered Service Plan. This service was redesigned with the goal making access to case management services more equitable.

A summary of the statistics for TCM case management services is provided below:

TCM - Case Management Statistics	
Total Adjusted Expenditures SFY 2023-24	\$51,621,578
Total Members Utilizing Services in SFY 2023-24	47,507
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	187.33%
Total Active Providers SFY 2023-24	28
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	40.00%

Table 59. TCM - Case Management total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The case management service grouping has four procedure code/modifier combinations. One procedure code (T2023HI) modifier combination (25%) was compared to similar services in other state Medicaid programs. Three codes (75%) were excluded because they did not have comparable benchmarks due to a lack of rates for equivalent services in other states.

The large percentage of codes without comparable rates is due to Colorado's unique FFS case management structure. Colorado has separate quarterly rates for monitoring visits, codes T2024+HI and T2024+HI,GT. Other states do not have a separate rate for monitoring visits and instead include them in the monthly case management benefit. Additionally, Colorado has a flat add-on rate applied to monitoring visits in rural areas using code and modifier combination A0170+HI. Alternatively, other states with a rural benefit for case management services base these rates off of time or mileage driven.

TCM - Case Management Benchmark States	
Procedure Code	Benchmark State
T2023+HI	Montana, Maine, Massachusetts Louisiana

Table 60. Case Management - case management benchmark states (SFY 2023-24).

T2023HI - the only code modifier combinations with a benchmark ratio - accounts for 87% of total payment amounts and 80% of total utilization for this category during SFY 2023-24.

Benchmark State Rationale

Montana, Maine, Massachusetts, and Louisiana were selected as benchmark states. While all four states were chosen because they have a FFS rate for case management services similar to Colorado's per member per month fee for service rate, there was no state that offered a direct comparison in terms of policy and payment structure.

See appendix D.4 for a detailed explanation of how benchmark rates were calculated.

On average, Colorado Medicaid payments for case management are estimated at 91.48% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

TCM - Case Management Repriced Benchmark Comparison			
Colorado Fee Schedule Rate Effective Date	Colorado Repriced	Montana, Maine, Massachusetts, and Louisiana Medicaid Repriced	Overall Repriced Benchmark Ratio
July 1, 2024	\$51,621,578	\$59,167,102	87.25%
July 1, 2025	\$54,128,215	\$59,167,102	91.48%

Table 61. Comparison of Colorado Medicaid TCM - case management service payments to those of other payers, expressed as a percentage (SFY 2023-24). The rate for T2023 HI received a targeted increase effective July 1, 2025. Because of this increase, the MPRRAC requested to see the benchmark ratio and fiscal impact based on the new rate.

The estimated fiscal impact to Colorado Medicaid would be \$7,545,524 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the TCM - case management panel size visual (Appendix B, Figure 85), the average number of utilizers per provider in urban areas appeared to have an upward trend. Finally, the drive time analysis (Appendix B, Figure 90) shows that some parts

of the state had relatively high drive times (over an hour). These findings suggest that longer distances may impact accessibility to services.

See Appendix B for the full access to care analysis.

Stakeholder Feedback

During the benchmark state selection analysis we consulted policy specialists in HCPF's Office of Community Living, provider organizations, and the third-party actuarial company CBIZ Optumas. HCPF policy specialists explained there are no states that would offer a direct comparison, but offered states which paid the same rate for case management services across different waiver programs and provided us with a list of states that fit this criteria (Oregon, Maine, Massachusetts, Minnesota, Washington). They reasoned that states with this payment model were better comparisons because they best matched Colorado's case management payment model following the case management redesign.

The provider organization Alliance Colorado endorsed using states where case management services are specifically for members with developmental disabilities. Their rationale was that the population of Health First Colorado members receiving case management services more closely resembles the member populations in these states. They also provided us with a list of states (Montana, Oklahoma, Missouri, Nebraska, Alabama) that they felt met this criteria.

Of the four states we used for our benchmark analysis, two states, Massachusetts and Maine, were from HCPF's policy experts, whereas one state, Montana, was from Alliance Colorado. The fourth state, Louisiana, was identified by CBIZ Optumas and has case management services designed specifically for persons with developmental disabilities.

- Massachusetts and Maine suggested by HCPF policy experts
- Montana suggested by Alliance
- Louisiana suggested by CBIZ Optumas

See Appendix I for Stakeholder Feedback.

MPRRAC Recommendations

- For TCM - case management services, the MPRRAC recommends increasing the monthly TCM rate T2023+HI (July 2025 rate) to 100% of the benchmark.
- For codes with valid Colorado rates but without benchmark ratios, the MPRRAC recommends an increase of 3% (July 2024 rate) to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation for all codes based on the July 1, 2025 fee schedule is estimated to be \$5,144,620 total funds, including \$2,572,310 General Fund.

HCPF Recommendations

- For TCM - case management services, HCPF recommends no change to the rates.
- For codes with valid Colorado rates but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Policy Justification

Due to this recent rate increase and budget constraints, maintaining the current rate aligns with the Medicaid Sustainability Framework. Each benchmark state's case management program varies significantly, making it difficult to establish a reliable benchmark comparison. Before any further rate adjustment, conducting a time study on the tasks associated with the TCM case management program would help capture the full scope of case management activities and determine an appropriate TCM rate. If resources for the time study are needed, they will be requested at a future date.

Targeted Case Management - Transition Coordination

Service Description

Transition coordination services support transition to a community setting from an institutional setting. This service is available to members over 18 living in congregate settings other than assisted living facilities or other group homes. This includes comprehensive assessments for transition, community risk assessments, development of a transition plan, referrals, and monitoring/follow-up activities. Provided by transition coordination agencies (TCAs), services continue until the member is successfully connected to Medicaid services within their residential community and the risk of community living discontinuity is assessed as minimal.

A summary of the statistics for TCM transition coordination services is provided below:

TCM - Transition Coordination Statistics	
Total Adjusted Expenditures SFY 2023-24	\$4,765,822
Total Members Utilizing Services in SFY 2023-24	1,080
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	23.85%
Total Active Providers SFY 2023-24	24
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.00%

Table 62. TCM - transition coordination total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Benchmark State Rational

Minnesota, South Dakota, and Missouri were selected as benchmark states. These states all offer transition coordination or targeted case management services which include transitional living at a FFS rate. However, we were not able to find any states that had a FFS rate for transitional services specifically for members moving from a congregate setting and to a community based setting. Other states, such as Massachusetts, that offer similar services provide them via managed care programs.

See Appendix D.5 for a detailed explanation of how benchmark rates were calculated.

The one code (T1017TL) analyzed in this service grouping was compared to 3 states. On average, Colorado Medicaid payments for transition coordination services are estimated at 122.54% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

TCM - Transition Coordination Repriced Benchmark Comparison		
Colorado Repriced	Minnesota, South Dakota, Missouri Repriced	Overall Repriced Benchmark Ratio
\$4,765,822	\$3,889,268	122.54%

Table 63. Comparison of Colorado Medicaid TCM - transition coordination service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$876,554 of total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the TCM - transition coordination panel size visual (Appendix B, Figure 91), the average number of utilizers per provider in urban areas had a decreasing trend. The special providers visual (Appendix B, Figure 94) shows that the percent of active providers that served only one Medicaid member increased then decreased. Finally, the drive time analysis (Appendix B, Figure 95) shows that much of the state had relatively high drive times (over an hour). These findings suggest that longer distances may impact accessibility if members must travel to a facility to receive services.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

MPRRAC Recommendations

- For TCM - transition coordination services, the MPRRAC recommends no change to the rates.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

HCPF Recommendations

- For TCM - transition coordination services, HCPF recommends no change to the rates.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Vision Services

Service Description

Vision services encompass a range of healthcare solutions aimed at improving and maintaining visual acuity and eye health including:

- Comprehensive eye examinations.
- Prescription and fitting of corrective lenses, including eyeglasses and contact lenses.
- Dispensing of eyeglasses, including frames and lenses.
- Diagnosis and treatment of eye diseases and conditions, including vision correction, eye surgery, and management of conditions like cataracts, glaucoma, and retinal diseases.

A summary of the statistics for the Vision service category is provided below:

Vision Services Statistics	
Total Adjusted Expenditures SFY 2023-24	\$115,875,903
Total Members Utilizing Services in SFY 2023-24	266,336
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-8.48%
Total Active Providers SFY 2023-24	2,286
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	5.69%

Table 64. Vision services total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

Vision Services is a newly created service category due to regrouping efforts after the March MPRRAC meeting, including all of the original “Physician Services - Ophthalmology” codes, majority of the original “Eyeglasses and Vision” codes, and four of the original “Physician Services - Other” codes. So the benchmark state list for the new vision services category is a combination of the original 3 subcategories (“Physician Services - Ophthalmology”: Arizona, Nebraska, Nevada, Oklahoma, Oregon and Utah; “Eyeglasses and Vision”: Arizona, California, Louisiana, Nevada and Oklahoma; “Physician Services - Other”: Arizona, Nebraska, Nevada, Oklahoma, Oregon and Utah). On top of that, we decided to add New Mexico to the benchmark state list only for original “Eyeglasses and Vision” codes as a balancing effort for California.

Vision services has 205 procedure code/modifier combinations. The rates for 178 of them (86.83%) were compared to Medicare, while the rates for 23 codes (11.22%) were compared to rates from other states (Arizona, California, Louisiana, Nevada, Oklahoma, Nebraska, Oregon, Utah, and New Mexico). Among these 205 codes, 34 of

them (16.59%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. There are 4 codes (2.25%) being excluded due to no benchmark rates. Individual rate ratios for vision services were 7.53% - 451.60%.

On average, Colorado Medicaid payments for vision services are estimated at 81.12% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below:

Vision Services Repriced Benchmark Comparison		
Colorado Repriced	Medicare and Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$115,875,903	\$142,837,407	81.12%

Table 65. Comparison of Colorado Medicaid vision service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$26,961,504 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the vision services panel size visual (Appendix B, Figure 96), the average number of utilizers per provider in urban and rural areas had similar spike patterns and overall trends. This was due to increased numbers of utilizers in August of each fiscal year, which coincides with back-to-school vision checks and eyeglasses fittings among the school-aged population. The special providers visual (Appendix B, Figure 99) shows that the percentage of active providers that served only one Medicaid member remained relatively stable. The drive time analysis (Appendix B, Figure 100) shows that drive times were relatively low statewide, with a few areas of Western Colorado having higher drive times (over an hour). These findings indicate that access to care is relatively stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

Benchmark State List Analysis

In April 2025, we received a provider's request to switch California to New Mexico in the benchmark state list for original "Eyeglasses and Vision" codes. Provider provided following reasoning: 1) California has some of the lowest vision fees in the country, with an extremely low utilization rate for vision services among children on Medicaid.

2) New Mexico's demographics and the cost-of-living index are much more comparable than California.

After receiving the provider's request, we conducted thorough research. We also reached out to the actuary company CBIZ Optumas and internal policy specialist to verify our research results. Our research and Analysis found:

1) Both California (lowest) and New Mexico (highest) have extreme vision rates;

Vision Services Benchmark States Rates Comparison							
Procedure Code	Colorado	Arizona	California	Louisiana	Nevada	Oklahoma	New Mexico
92015	15.63	18.24	5.69	N/A	19.27	19.94	30.29
92310	97.26	95.73	25.83	N/A	92.27	101.46	252.96
92340	27.10	33.21	7.64	13.58	34.29	35.16	53.41
92341	30.93	38.09	11.28	13.58	39.00	40.39	61.44
92370	19.11	28.98	4.47	N/A	29.85	30.74	46.75

Table 66. Vision Services Benchmark States Rates Comparison

2) There is not a substantial difference in terms of vision utilization rates between California and New Mexico ([CDC Vision and Eye Health Surveillance System \(VEHSS\)](#));

3) Neither California nor New Mexico are similar to Colorado's demographics according to demographic data and cost of living index (COLA) data.

We carefully communicated our research findings with the provider and offered two options: 1) Remove CA from the benchmark state list; 2) Keep CA in the benchmark state list but also add NM to balance. Ultimately, the provider preferred option number 2. As such, the final decision was to keep CA in the benchmark state list but also add NM to balance.

After this update, the current benchmark state list for vision services is: Arizona, California, Louisiana, Nevada, Oklahoma, Nebraska, Oregon, Utah, and New Mexico.

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the procedure code/modifier combinations for vision services.

Vision Services Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	V2784	LENS POLYCARB OR EQUAL	77.7%	334,216	16.52%
2	V2750	ANTI-REFLECTIVE COATING	77.7%	239,096	11.82%
3	V2410	LENS VARIAB ASPHERICITY SING	77.7%	228,212	11.28%
4	92340	FIT SPECTACLES MONOFOCAL	91.7%	165,725	8.19%
5	V2103	SPHEROCYLINDR 4.00D/12-2.00D	77.7%	161,229	7.97%
6	V2020	VISION SVCS FRAMES PURCHASES	77.7%	139,500	6.90%
7	92014	COMPRES OPH EXAM EST PT 1/>	90.9%	121,290	6.00%
8	V2203	LENS SPHCYL BIFOCAL 4.00D/.1	77.7%	102,074	5.05%
9	92004	EYE EXAM NEW PATIENT	92.3%	83,644	4.14%
10	V2104	SPHEROCYLINDR 4.00D/2.12-4D	77.7%	61,207	3.03%

Table 67. Vision services top 10 procedure codes ranked by utilization

Outlier Analysis

The MPRRAC requested to view data on the outliers for each service category. Outliers are defined as Colorado Medicaid reimbursement rates that are below 60% or above 140% of the benchmark. The bubble chart below indicates that there are three procedure code/modifier combinations with rates above 140% of the benchmark rate. To protect PHI, 5 outliers with low utilization were excluded from the chart. Additionally, no outliers with benchmark ratio below 60% were identified.

Figure 13 shows that there are three procedure code/modifier combinations: 92065, 92025+26, and 92134+26, with valid SFY 2023-24 utilization above 140% of the benchmark. Utilization for these codes was modest: 92065 (2,621, with \$148,060 Health First Colorado repriced amount), 92025+26 (682, with \$20,992 Health First Colorado repriced amount), and 92134+26 (2,556, with \$64,444 Health First Colorado repriced amount).

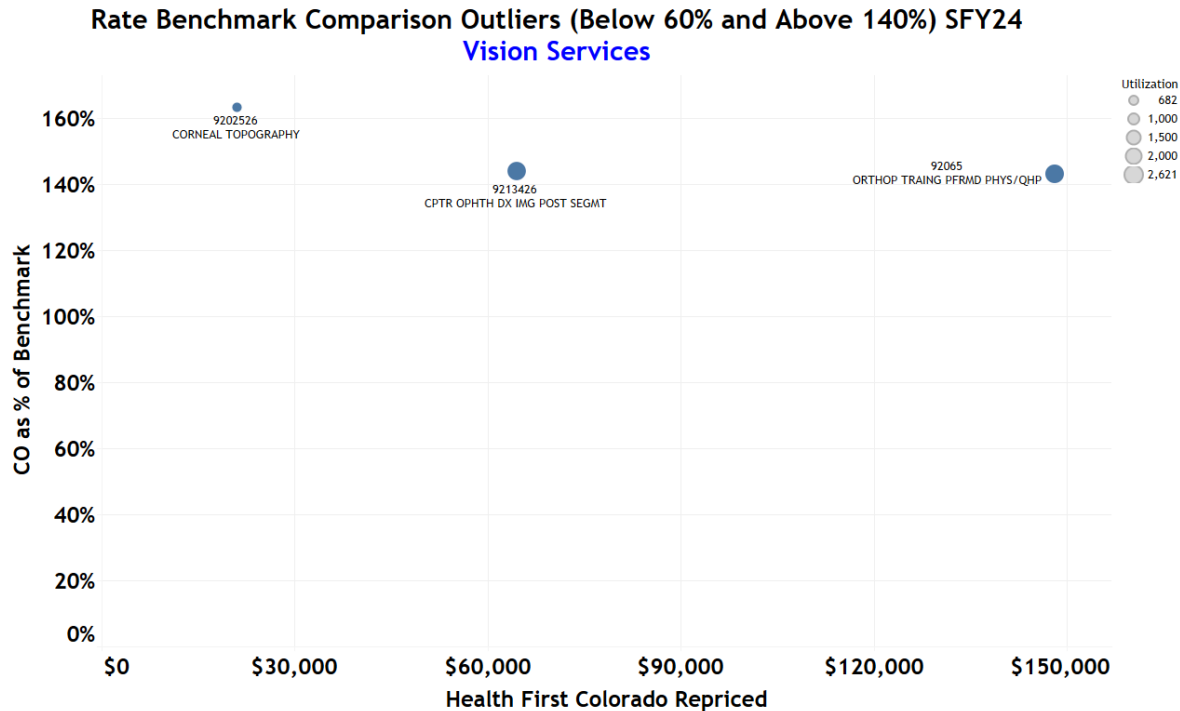


Figure 13. Bubble Chart indicating the outliers below 60% and over 140% found for vision services

Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the vision services category. Preventive services play a critical role in reducing the need for more complex procedures.

We received preventive code recommendations from Dr. Emily McCourt, MD, Chief of Pediatric Ophthalmology at Children's Hospital Colorado.

There are 11 preventive codes (5.4% of total vision services codes, 92015 and 92060 are only for kids under age of 8) in this service grouping, 7 of these 11 codes (63.63%) use Medicare for benchmarking. The benchmark ratio range for these codes is 86.3% - 114.0%,

As shown in table below, Vision services' preventive codes have a low utilization percentage, account for a small portion of total expenditures, and amount to nearly 100% of the overall benchmark ratio.

Service Category	Potential Preventive Code Count	Utilization Percentage	CO Repriced Amount Percentage	Overall Benchmark Ratio
Vision Services	11	13.63%	22.79%	91.50%

Table 68. Vision services preventive codes analysis

MPRRAC Recommendations

- The MPRRAC recommends adjusting the rates of codes below 80% of the benchmark rate up to 80%, and keep the rates that are above 80% of the benchmark the same.
- The MPRRAC recommends for codes with valid Colorado rate but without benchmark rates, a rate increase of 3% to account for inflation.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$3,268,733 total funds, including \$896,287 General Fund, when extrapolated to a full year.

HCPF Recommendations

- HCPF recommends increasing the rates for all codes under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 85% of the benchmark to 85% of the benchmark.
- For codes with valid Colorado rate but without benchmark rates, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$380,327 Total Funds, including \$104,286 General Fund.

Physician Services - Overview

Service Description

Physician Services refer to a broad category of healthcare services delivered by licensed medical professionals, including physicians and other qualified providers. These services encompass evaluation, diagnosis, treatment, and management of a wide range of health conditions across all age groups.

Services included under this category are:

- Allergy and Immunology
- Cardiology
- Dermatology
- Emergency Department (ED) and Hospital Evaluation and Management (E&M)
- Ear, Nose, and Throat (ENT)
- Family Planning
- Gastroenterology
- Gynecology
- Health Education
- Medication Injections & Infusions
- Neuro/Psychological Testing Services
- Neurology
- Primary Care E&M
- Radiology
- Respiratory
- Sleep Study
- Vaccines Immunizations
- Vascular

Benchmark Rationale

The rates for physician services were compared to Medicare and the rates from 6 benchmark states: Arizona, Nebraska, Nevada, Oklahoma, Oregon, and Utah. These states were chosen as benchmarks for the rate comparison analysis because they have comparable benefit packages and covered populations to Colorado. Additionally, all of the benchmark states are geographically close to Colorado. With some of the physician service subcategories, the primary providers are specialists and the other state benchmarks share similar economic and healthcare delivery characteristics with Colorado, including rural and frontier areas where physician access is a challenge. Many of the regions around Colorado tend to have lower physician-to-population ratios, making them relevant for assessing whether reimbursement rates impact workforce availability.

When comparing procedure code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models,

services not being covered, or variations in state-specific service definitions. This leads to inconsistencies in the number of benchmark states available for different codes. For more information on the benchmark states used for a particular code, please see Appendix D.

Preventive Codes

In the context of healthcare, a preventive code refers to a specific medical code used to report and bill for preventive medicine services or preventive care provided to patients. These services aim to prevent illness or detect it early, and they are often part of routine well-visits, screenings, and immunizations.

HCPF policy specialist used the United State Preventive Services Task Force A and B level recommendations as guidance to identify prevention services (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>).

Physician Services - Allergy and Immunology

Service Description

Allergy and immunology is a medical specialty focused on the diagnosis, treatment, and management of allergic conditions and disorders of the immune system. This includes evaluation and care for conditions such as allergic rhinitis, asthma, eczema, food allergies, drug allergies, insect sting allergies, and anaphylaxis, as well as immune system disorders like primary immunodeficiencies and autoimmune diseases. Services in this category include allergy testing, immunotherapy, pulmonary function testing, and management of chronic or complex allergic and immunologic conditions.

A summary of the statistics for the allergy and immunology service subcategory is provided below:

Physician Services - Allergy and Immunology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$4,573,865
Total Members Utilizing Services in SFY 2023-24	11,560
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.27%
Total Active Providers SFY 2023-24	383
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	1.86%

Table 69. Physician Services - Allergy and Immunology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The allergy and immunology service grouping has 32 procedure code/modifier combinations. The rates for 26 of them (81.25%) were compared to Medicare, while the rates for six codes (18.75%) were compared to rates from other states:

Physician Services - Allergy and Immunology Benchmark States	
Procedure Code	Benchmark State ¹⁶
95120	Arizona, Nebraska, Nevada, and Oregon
95130	Nebraska, Nevada, Oregon, and Utah
95131, 95132, 95133, and 95134	Arizona, Nebraska, Nevada, Oregon, and Utah

Table 70. Physician Services - Allergy and Immunology Benchmark States (SFY 2023-24).

Among these 32 codes, 12 of them (37.5%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for allergy and immunology were 2.85% - 115.73%.

¹⁶ Please refer to the "Benchmark Rationale" provided under "Physician Services" on page 108 for benchmark rationale for all physician services.

On average, Colorado Medicaid payments for allergy and immunology are estimated at 90.03% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Allergy and Immunology Repriced Benchmark Comparison		
Colorado Repriced	Medicare Repriced ¹⁷	Overall Repriced Benchmark Ratio
\$4,573,865	\$5,080,181	90.03%

Table 71. Comparison of Colorado Medicaid Physician Services - Allergy and Immunology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$506,316 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the allergy and immunology panel size visual (Appendix B, Figure 101), the average number of utilizers per provider in urban areas increased then decreased. The special providers visual (Appendix B, Figure 104) shows that the percent of active providers that served only one Medicaid member was stable. The drive time analysis (Appendix B, Figure 105) shows that drive times were relatively low statewide, although some areas in Eastern and Western Colorado were affected by higher drive times (over an hour). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - allergy and immunology.

Physician Services - Allergy and Immunology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization

¹⁷ Medicare was the only comparator used for the benchmark repriced amount. Other states were used as benchmarks for codes without valid SFY 2023-24 utilization data.

1	95004	PERCUT ALLERGY SKIN TESTS	93.1%	309,464	51.56%
2	95165	ANTIGEN THERAPY SERVICES	89.0%	186,604	31.09%
3	95117	IMMUNOTHERAPY INJECTIONS	100.7%	38,746	6.46%
4	95044	ALLERGY PATCH TESTS	84.8%	26,966	4.49%
5	95024	ICUT ALLERGY TEST DRUG/BUG	88.9%	17,599	2.93%
6	95115	IMMUNOTHERAPY ONE INJECTION	90.5%	12,227	2.04%
7	95144	ANTIGEN THERAPY SERVICES	49.9%	4,310	0.72%
8	95180	RAPID DESENSITIZATION	82.6%	1,024	0.17%
9	95018	PERQ&IC ALLG TEST DRUGS/BIOL	96.6%	910	0.15%
10	95076	INGEST CHALLENGE INI 120 MIN	81.8%	669	0.11%

Table 72. Physician Services - Allergy and Immunology top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, one outlier with low utilization and a benchmark ratio below 60% was excluded from this service category. Additionally, no outliers with benchmark ratio above 140% were identified.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - Allergy and Immunology

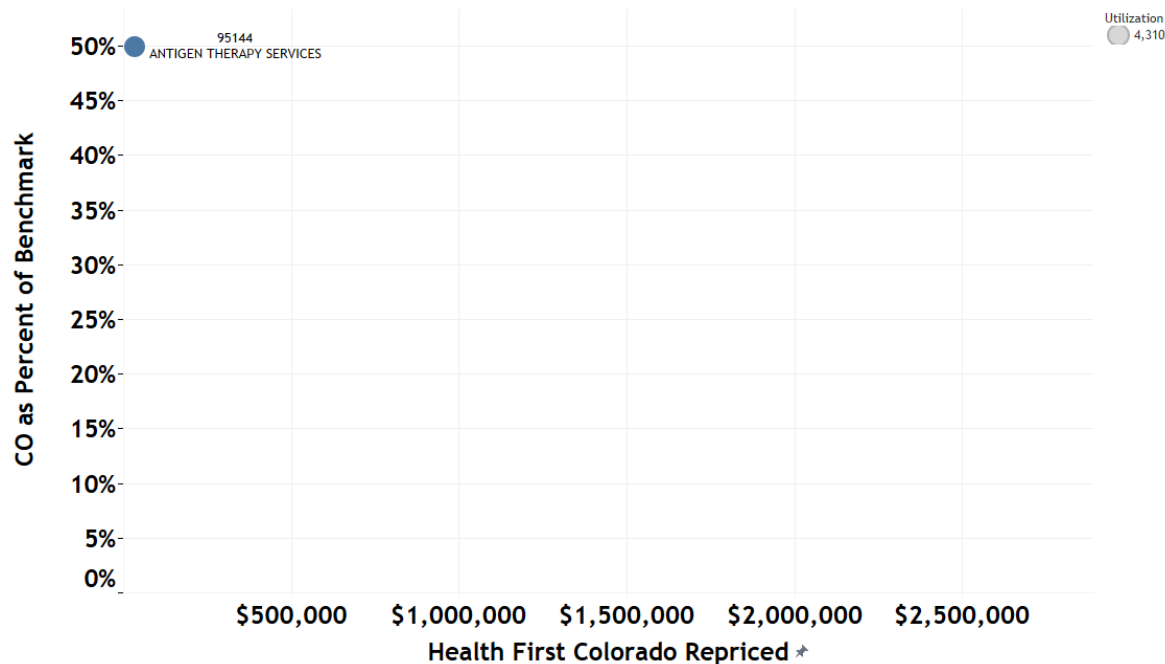


Figure 14. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Allergy and Immunology

The bubble chart above (Figure 14) indicates that one outlier, 95144, has a benchmark ratio of 49.91%. It recorded 4,310 allowed units, accounting for 0.72% of the total utilization, and a repriced amount of \$35,558, or 0.78% of the total expenditure.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and keeping the rates for all codes above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$21,470 total funds, including \$5,887 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and keeping the rates for all codes above 80% of the benchmark the same.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$21,470 total funds, including \$5,887 General Fund.

Physician Services - Cardiology

Service Description

Cardiology services encompass a comprehensive range of medical care focused on diagnosing, treating, and managing diseases of the heart and blood vessels. Cardiology Services aim to improve patients' cardiovascular health, manage chronic conditions, and enhance overall quality of life through expert care and advanced medical technologies.

A summary of the statistics for the cardiology service subcategory is provided below:

Physician Services - Cardiology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$7,586,984
Total Members Utilizing Services in SFY 2023-24	103,706
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-7.39%
Total Active Providers SFY 2023-24	5,194
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	1.07%

Table 73. Physician Services - Cardiology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The cardiology service grouping has 333 procedure code/modifier combinations. The rates for 274 of them (82.28%) were compared to Medicare, while the rates for 52 codes (15.62%) were compared to rates from other states. Among these 326 codes with benchmark ratios, 145 of them (44.48%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, seven combinations (2.1%) are excluded due to no valid benchmark rates found. Individual rate ratios for cardiology were 14.45% - 572.22%.

On average, Colorado Medicaid payments for cardiology are estimated at 95.03% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Cardiology Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$7,586,984	\$7,983,635	95.03%

Table 74. Comparison of Colorado Medicaid Physician Services - Cardiology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$396,651 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the cardiology panel size visual (Appendix B, Figure 106), the average number of utilizers per provider in urban and rural regions was stable. The penetration rate visual (Appendix B, Figure 108) shows that several counties throughout the state had moderately high penetration rates. The percentage of active providers serving Medicaid members was 43% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 109) shows that the percentage of active providers that served only one Medicaid member was stable. Statewide per utilizer per year Medicaid expenditures (Appendix B, Figure 110) were lower than all other payers (Medicare FFS, Medicare Advantage, and commercial payers), while per utilizer per year Medicaid utilization (Figure 111) was higher than most payers. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - cardiology.

Physician Services - Cardiology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	93010	ELECTROCARDIOGRAM REPORT	106.4%	136,745	51.46%
2	93306+26	TTE W/DOPPLER COMPLETE	86.9%	26,558	9.99%
3	93000	ELECTROCARDIOGRAM COMPLETE	105.6%	26,350	9.92%

4	93325+26	DOPPLER COLOR FLOW ADD-ON	106.8%	9,322	3.51%
5	93320+26	DOPPLER ECHO EXAM HEART	106.5%	6,670	2.51%
6	93303+26	ECHO TRANSTHORACIC	113.1%	5,465	2.06%
7	93308+26	TTE F-UP OR LMTD	106.4%	4,430	1.67%
8	93018	CARDIOVASCULAR STRESS TEST	103.8%	3,699	1.39%
9	93306	TTE W/DOPPLER COMPLETE	110.2%	3,558	1.34%
10	93298	REM INTERROG DEV EVAL SCRMS	23.6%	2,914	1.10%

Table 75. Physician Services - Cardiology top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, eight outliers with low utilization were excluded from this service category; four of these were outliers with benchmark ratios below 60%, and four of these were outliers with benchmark ratios above 140%.

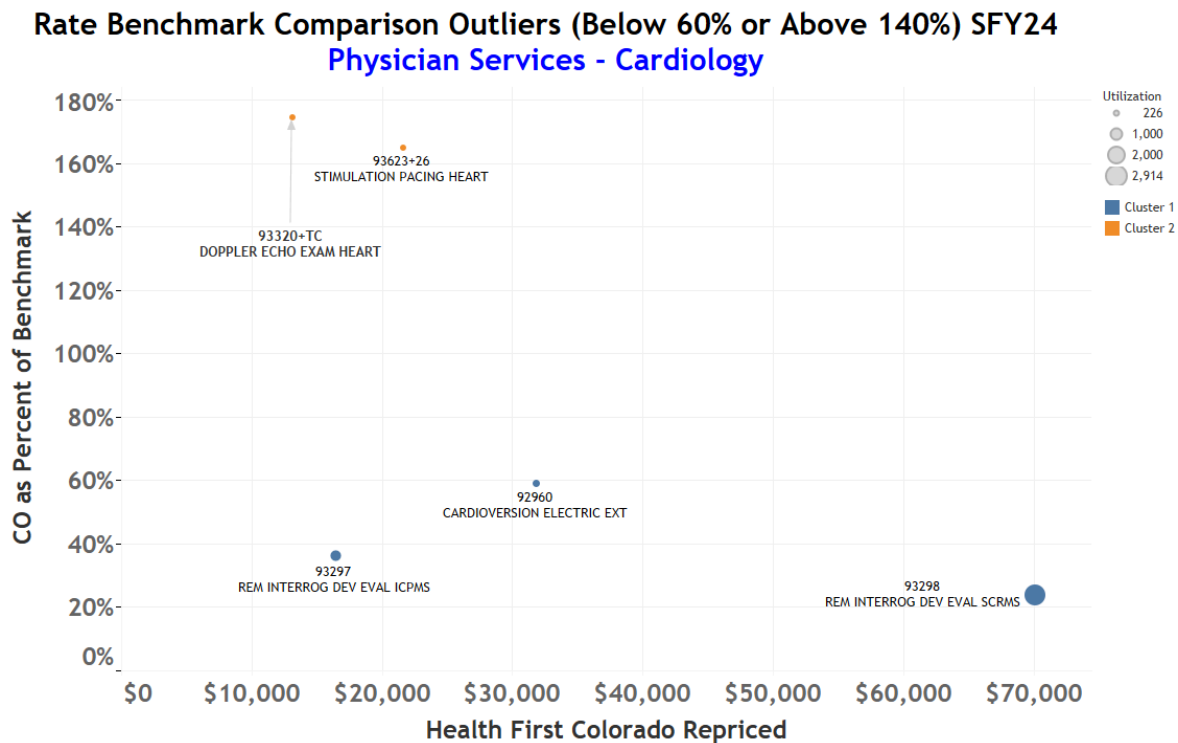


Figure 15. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Cardiology

The bubble chart above (Figure 15) indicates that there are two procedure codes reimbursed at less than 60% of the benchmark and three codes reimbursed at more than 140% of the benchmark. These five outliers are grouped into two clusters:

- Cluster 1 includes three outliers, procedure codes 93298, 93297, and 92960, with benchmark ratio ranging between 23.64% - 59.05%. Their repriced amounts range between \$16,446 to \$70,118, and their utilization ranges from 355 - 2914 allowed units. Overall, cluster 1 contains outliers with benchmark ratios below 60%.
- Cluster 2 includes two procedure code/modifier combinations 93623+26, and 93320+TC, with benchmark ratio ranging between 164.93% and 174.36%. Their repriced amounts are \$21,599 (0.47% of total) and \$13,126 (0.29% of total), and their utilization amounts are 253 and 226 allowed units (0.04% of total), respectively. Overall, cluster 2 contains outliers above 140% of benchmark ration with small utilization.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$194,302 total funds, including \$53,278 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 100% of benchmark to 100% of the benchmark due to budget constraints.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$90,119 total funds, including -\$24,711 General Fund.

Physician Services - Dermatology

Service Description

Dermatology is a medical specialty concerned with the diagnosis, treatment, and prevention of conditions affecting the skin, hair, nails, and mucous membranes. This includes a wide range of acute and chronic conditions such as acne, eczema, psoriasis, dermatitis, fungal infections, skin cancers, and pigmentary disorders. Dermatology also encompasses the treatment of cosmetic concerns and the monitoring of skin changes that may indicate systemic disease.

A summary of the statistics for the dermatology service subcategory is provided below:

Physician Services - Dermatology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$1,117,698
Total Members Utilizing Services in SFY 2023-24	10,468
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-13.54%
Total Active Providers SFY 2023-24	2,989
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-4.87%

Table 76. Physician Services - Dermatology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The dermatology service grouping has 26 procedure code/modifier combinations. All rates were compared to Medicare. Among these 26 codes, 12 of them (46.15%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for dermatology were 16.70% - 119.99%.

On average, Colorado Medicaid payments for dermatology are estimated at 76.73% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Dermatology Repriced Benchmark Comparison		
Colorado Repriced	Medicare	Overall Repriced Benchmark Ratio
\$1,117,698	\$1,456,605	76.73%

Table 77. Comparison of Colorado Medicaid Physician Services - Dermatology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$338,907 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the dermatology panel size visual (Appendix B, Figure 112), the average number of utilizers per provider in urban and rural regions was overall stable. The special providers visual (Appendix B, Figure 115) shows that the percentage of active providers that served only one Medicaid member was stable. The drive time analysis (Appendix B, Figure 116) shows that drive times were relatively low statewide, although some parts of Western Colorado had higher drive times (over an hour). These findings suggest that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - dermatology.

Physician Services - Dermatology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	11102	TANGNTL BX SKIN SINGLE LES	82.2%	4,946	35.19%
2	10060	DRAINAGE OF SKIN ABSCESS	72.1%	4,385	31.20%
3	11103	TANGNTL BX SKIN EA SEP/ADDL	81.8%	1,685	11.99%
4	11200	REMOVAL OF SKIN TAGS <W/15	80.1%	982	6.99%
5	10120	REMOVE FOREIGN BODY	64.7%	885	6.30%
6	96900	ULTRAVIOLET LIGHT THERAPY	82.9%	509	3.62%
7	96910	PHOTOCHEMOTHERAPY WITH UV-B	85.7%	274	1.95%
8	11440	EXC FACE-MM B9+MARG 0.5 CM/<	76.6%	126	0.90%
9	96920	EXCIMER LSR PSRIASIS<250SQCM	93.9%	76	0.54%
10	11310	SHAVE SKIN LESION 0.5 CM/<	84.1%	72	0.51%

Table 78. Physician Services - Dermatology top 10 procedure codes ranked by utilization

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and keeping the rates for all codes above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$65,597 total funds, including \$17,987 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and keeping the rates for all codes above 80% of the benchmark the same.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$65,597 total funds, including \$17,987 General Fund.

Physician Services - Emergency Department (ED) and Hospital Evaluation and Management (E&M)

Service Description

ED and hospital E&M encompass the assessment, diagnosis, and management of patients in acute care settings, including emergency departments, inpatient hospital units, observation status, and critical care environments. These services are provided by physicians and qualified healthcare professionals to address a wide range of medical conditions, from minor injuries and illness to complex, life-threatening emergencies.

Please note: Hospital facility payments are not part of this service subcategory.

A summary of the statistics for the ED and hospital E&M service subcategory is provided below:

Physician Services - ED and Hospital E&M Statistics	
Total Adjusted Expenditures SFY 2023-24	\$172,992,583
Total Members Utilizing Services in SFY 2023-24	358,222
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-10.15%
Total Active Providers SFY 2023-24	11,7563
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.93%

Table 79. Physician Services - ED and Hospital E&M total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The ED and hospital E&M service grouping has 50 procedure code/modifier combinations. The rates for 46 of them (92%) were compared to Medicare. Among these 46 codes, four of them (8.7%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. The rates for two of the 50 code combinations (4%) were compared to rates from other states:

Physician Services - ED and Hospital E&M Benchmark States	
Procedure Code	Benchmark State ¹⁸
99360	Arizona, Nebraska, Nevada, Oklahoma, and Oregon
99418	Arizona, Nebraska, Nevada, Oregon, and Utah

Table 80. Physician Services - ED and Hospital E&M Benchmark States (SFY 2023-24).

¹⁸ Please refer to the “Benchmark Rationale” provided under “Physician Services” on page 108 for benchmark rationale for all physician services.

Moreover, two combinations (4%) are excluded due to no valid benchmark rates found. Individual rate ratios for cardiology were 10.07% - 123.85%.

On average, Colorado Medicaid payments for ED and Hospital E&M are estimated at 90.83% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

ED and Hospital E&M Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$172,992,583	\$190,465,436	90.83%

Table 81. Comparison of Colorado Medicaid Physician Services - ED and Hospital E&M service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$17,472,853 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the ED hospital E&M panel size visual (Appendix B, Figure 117), the average number of utilizers per provider in urban areas had a downward trend. The penetration rate visual (Appendix B, Figure 119) shows that utilization per 1000 members was moderate in several counties throughout the state. The drive time analysis (Appendix B, Figure 105) shows that drive times were relatively low statewide, although some parts of Eastern and Western Colorado were affected by higher drive times (over an hour). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - ED and hospital E&M.

Physician Services - ED and Hospital E&M Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	99284	EMERGENCY DEPT VISIT MOD MDM	89.4%	297,008	19.12%
2	99232	SBSQ HOSP IP/OBS MODERATE 35	84.4%	215,580	13.88%
3	99233	SBSQ HOSP IP/OBS HIGH 50	85.0%	198,301	12.76%
4	99285	EMERGENCY DEPT VISIT HI MDM	92.0%	181,234	11.66%
5	99283	EMERGENCY DEPT VISIT LOW MDM	85.7%	120,064	7.73%
6	99223	1ST HOSP IP/OBS HIGH 75	97.8%	77,978	5.02%
7	99291	CRITICAL CARE FIRST HOUR	89.4%	73,530	4.73%
8	99239	HOSP IP/OBS DSCHRG MGMT >30	84.3%	55,602	3.58%
9	99231	SBSQ HOSP IP/OBS SF/LOW 25	71.3%	55,258	3.56%
10	99222	1ST HOSP IP/OBS MODERATE 55	88.6%	46,974	3.02%

Table 82. Physician Services - ED and Hospital E&M top 10 procedure codes ranked by utilization

Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the ED and hospital E&M service subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

There are four preventive codes (8%) in this service grouping and the benchmark ratio range is 107.23% - 110.77%, indicating that Colorado's Medicaid reimbursement levels for these preventive codes are reasonably aligned with Medicare rates.

CODE	Service Description	Utilization	% of Total Utilization	Benchmark Source
99460	INIT NB EM PER DAY HOSP	15,323	0.99%	Medicare
99461	INIT NB EM PER DAY NON-FAC	169	0.01%	Medicare
99462	SBSQ NB EM PER DAY HOSP	6,596	0.42%	Medicare
99463	SAME DAY NB DISCHARGE	1,692	0.11%	Medicare

Table 83. Physician Services - ED and Hospital E&M preventive codes analysis

MPRRAC Recommendations

- The MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and keeping the rates for all codes above 80% of the benchmark the same.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$278,538 total funds, including \$76,375 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints. However, HCPF recommends keeping the rate for preventive codes (99460, 99461, 99462, and 99463) the same.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$1,203,838 total funds, including -\$330,092 General Fund.

Physician Services - Ear, Nose, and Throat (ENT)

Service Description

ENT services, also known as otolaryngology, encompass a comprehensive range of medical and surgical care for conditions affecting the ears, nose, throat, and related structures of the head and neck.

A summary of the statistics for the ENT service subcategory is provided below:

Physician Services - ENT Statistics	
Total Adjusted Expenditures SFY 2023-24	\$2,498,640
Total Members Utilizing Services in SFY 2023-24	42,439
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-5.20%
Total Active Providers SFY 2023-24	1,167
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	0.09%

Table 84. Physician Services - ENT total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The ENT service grouping has 112 procedure code/modifier combinations. The rates for 101 of them (90.18%) were compared to Medicare, the rates for 10 of them (8.93%) were compared to rates from other states:

Physician Services - ENT Benchmark States	
Procedure Code	Benchmark State ¹⁹
92507+GT, 92551, 92650	Arizona, Nebraska, Nevada, Oklahoma, Oregon, and Utah
92558	Arizona, Nebraska, Oregon, and Utah
92605	Arizona, and Nevada
92630, 92633	Arizona, Oklahoma, and Oregon
92633, 92534	Arizona, Nevada, and Utah
92606	Arizona, Nevada, and Oklahoma

Table 85. Physician Services - ENT Benchmark States (SFY 2023-24).

Among these 111 codes with benchmark ratios, 39 of them (35.14%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, one combination (0.89%) is excluded due to no valid benchmark rates found. Individual rate ratios for ENT were 2.36% - 867.26%.

¹⁹ Please refer to the "Benchmark Rationale" provided under "Physician Services" on page 108 for benchmark rationale for physician services.

On average, Colorado Medicaid payments for ENT are estimated at 86.77% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

ENT Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$2,498,640	\$2,879,756	86.77%

Table 86. Comparison of Colorado Medicaid Physician Services - ENT service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$381,116 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the ENT panel size visual (Appendix B, Figure 122), the average number of utilizers per provider in urban and rural areas had similar patterns and trends from SFY 2021-22 to SFY 2023-24. The statewide provider participation rate was 29% in SFY 2023-24. The drive time analysis (Appendix B, Figure 105) shows that drive times were relatively low statewide, although some parts of Eastern and Western Colorado were affected by higher drive times (over an hour). Additionally, Colorado Medicaid had higher per utilizer per year (PUPY) expenditures and utilization than most payers (Appendix B, Figures 126 & 127). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - ENT.

Physician Services - ENT Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	92551	PURE TONE HEARING TEST AIR	108.9%	15,513	19.37%
2	92567	TYMPANOMETRY	87.0%	14,492	18.10%
3	92587	EVOKED AUDITORY TEST LIMITED	106.5%	6,684	8.35%
4	92557	COMPREHENSIVE HEARING TEST	86.0%	6,481	8.09%
5	92552	PURE TONE AUDIOMETRY AIR	75.2%	5,964	7.45%
6	92633	AUD REHAB POSTLING HEAR LOSS	68.1%	4,028	5.03%
7	92555	SPEECH THRESHOLD AUDIOMETRY	76.8%	2,780	3.47%
8	92579	VISUAL AUDIOMETRY (VRA)	86.5%	2,601	3.25%
9	92650	AEP SCR AUDITORY POTENTIAL	141.7%	2,571	3.21%
10	92582	CONDITIONING PLAY AUDIOMETRY	77.6%	1,868	2.33%

Table 87. Physician Services - ENT top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, four outliers with low utilization were excluded from this service category; three of these were outliers with benchmark ratios below 60%, and one of these were outliers with benchmark ratios above 140%.

The bubble chart below (Figure 16) indicates that there are four outliers displayed for ENT service grouping:

- Three outliers, 92511, 92540+TC, and 92612, have benchmark ratios below 60%, ranging from 33.60% to 37.52%. Among them, code 92612 has the lowest utilization, with only 34 allowed units (0.04% of the total). Code/modifier combination, 92540+TC, has the smallest repriced amount at \$798, representing just 0.03% of the total.
- One outlier, 92650, has a benchmark ratio of 141.66%. It recorded 2,571 allowed units, accounting for 3.21% of the total utilization, and a repriced amount of \$83,895, or 3.36% of the total expenditure.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - ENT

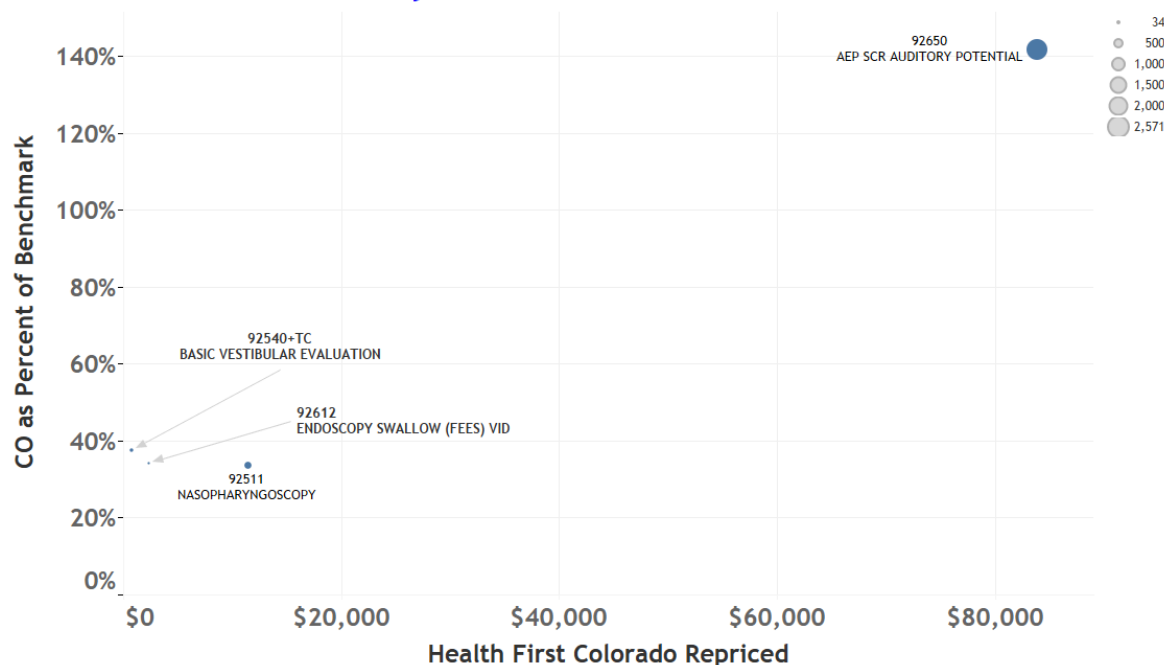


Figure 16. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - ENT

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$79,398 total funds, including \$21,771 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$2,538 total funds, including \$696 General Fund.

Physician Services - Family Planning

Service Description

Family planning services are preventive services that focus on sexual and reproductive health with the intent to delay, prevent or plan for a pregnancy. These include all FDA (Food and Drug Administration) approved contraceptives, pregnancy tests, sterilization services and basic fertility services. The scope of these services range from device insertion to basic fertility counseling.

A summary of the statistics for the Family Planning service subcategory is provided below:

Physician Services - Family Planning Statistics	
Total Adjusted Expenditures SFY 2023-24	\$8,132,832
Total Members Utilizing Services in SFY 2023-24	36,609
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-18.18%
Total Active Providers SFY 2023-24	3,7163
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-1.85%

Table 88. Physician Services - Family Planning total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The family planning service grouping has 59 procedure code/modifier combinations. The rates for 41 of them (69.49%) were compared to Medicare, while the rates for 18 codes (30.51%) were compared to rates from other states. Among these 59 codes, six of them (10.17%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for family planning were 21.64% - 384.60%.

On average, Colorado Medicaid payments for family planning are estimated at 113.86% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Family Planning Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$8,132,832	\$7,142,821	113.86%

Table 89. Comparison of Colorado Medicaid Physician Services - Family Planning service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$990,011 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the family planning panel size visual (Appendix B, Figure 128), the average number of utilizers per provider in urban and rural areas had a slight downward trend from SFY 2021-22 to SFY 2023-24. The percentage of active providers that served Medicaid members was 98% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 131) shows that the percent of active providers that served only one Medicaid member had an increasing trend from SFY 2021-22 to SFY 2023-24. This includes an individual provider and group practice who shifted their care focus, service area, and/or coverage provided, as well as providers who reduced their numbers of hours worked. As such, these events caused a reduction in the number of Medicaid patients seen among applicable providers. Finally, Colorado Medicaid had higher per utilizer per year (PUPY) utilization than other payers (Appendix B, Figures 126 & 127). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

The family planning service subcategory has an overall benchmark ratio of 113.86%, indicating that Colorado Medicaid reimbursement exceeds Medicare and peer state benchmarks on average. To better understand this high benchmark ratio, the policy specialist from the Policy Innovation & Benefit Team in the Health Policy Office was engaged. Through the consultation, it was clarified that during multiple legislative sessions, including in 2014 and 2018, the Colorado General Assembly approved targeted rate increases for selected providers, HCPCS codes, and specialties. These adjustments aimed to address significant rate disparities and to align reimbursement with the Department's emphasis on high-value services for clients. Rates for certain family planning related codes were among those increased as part of this effort, thus explaining this elevated overall repriced benchmark ratio.

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - family planning.

Physician Services - Family Planning Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	S4993+FP	CONTRACEPTIVE PILLS FOR BC	113.4%	25,109	29.93%
2	99213+FP	OFFICE O/P EST LOW 20-29 MIN	97.4%	13,115	15.63%
3	99214+FP	OFFICE O/P EST MOD 30-39 MIN	101.7%	9,604	11.45%
4	58300+FP	INSERT INTRAUTERINE DEVICE	72.8%	5,745	6.85%
5	58301+FP	REMOVE INTRAUTERINE DEVICE	80.8%	4,754	5.67%
6	99203+FP	OFFICE O/P NEW LOW 30-44 MIN	118.4%	3,841	4.58%
7	99212+FP	OFFICE O/P EST SF 10-19 MIN	94.6%	3,623	4.32%
8	11981+FP	INSERTION DRUG DLVR IMPLANT	323.2%	3,137	3.74%
9	99204+FP	OFFICE O/P NEW MOD 45-59 MIN	120.4%	2,592	3.09%
10	11982+FP	REMOVE DRUG IMPLANT DEVICE	174.4%	2,190	2.61%

Table 90. Physician Services - Family Planning top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, six outliers with low utilization were excluded from this service category, and all of them have a benchmark ratio above 140%.

The bubble chart below (Figure 17) indicates that there are two procedure codes (A4267, 76830+TC), with benchmark ratios under 60%, and nine codes (76856, 99203+GT, 99204+GT, 99202+GT, 11983, 76857, 11976, 11981, and 11982), with benchmark ratios above 140% displayed for family planning service grouping. These 11 outliers are grouped into 3 clusters:

- Cluster 1 includes nine outliers, with benchmark ratio ranging between 21.64% - 213.92%. Their repriced amounts range between \$539 (code A4267) to \$219,932 (code 11893), and their utilization ranges from 34 (code 99202) to 1586 (code A4267) allowed units. Code A4267 (Male Condom) has the highest utilization and lowest repriced amount. Overall, cluster 1 contains outliers with lower utilization and lowest repriced amounts among all outliers.
- Cluster 2 includes one procedure code, 11981, with benchmark ratio at 323.17%. Its repriced amount is at \$1,009,334 (12.41% of the total), and the utilization amount is 3,137 allowed units (3.74% of the total), the 8th highest utilized code in this service subcategory.

- Cluster 3 includes one procedure code, 119812, with benchmark ratio at 174.42%. Its repriced amount is at \$413,850 (5.09% of the total), and the utilization amount is 2,190 allowed units (2.61% of total). Both values are at the 2nd highest among all outliers.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - Family Planning

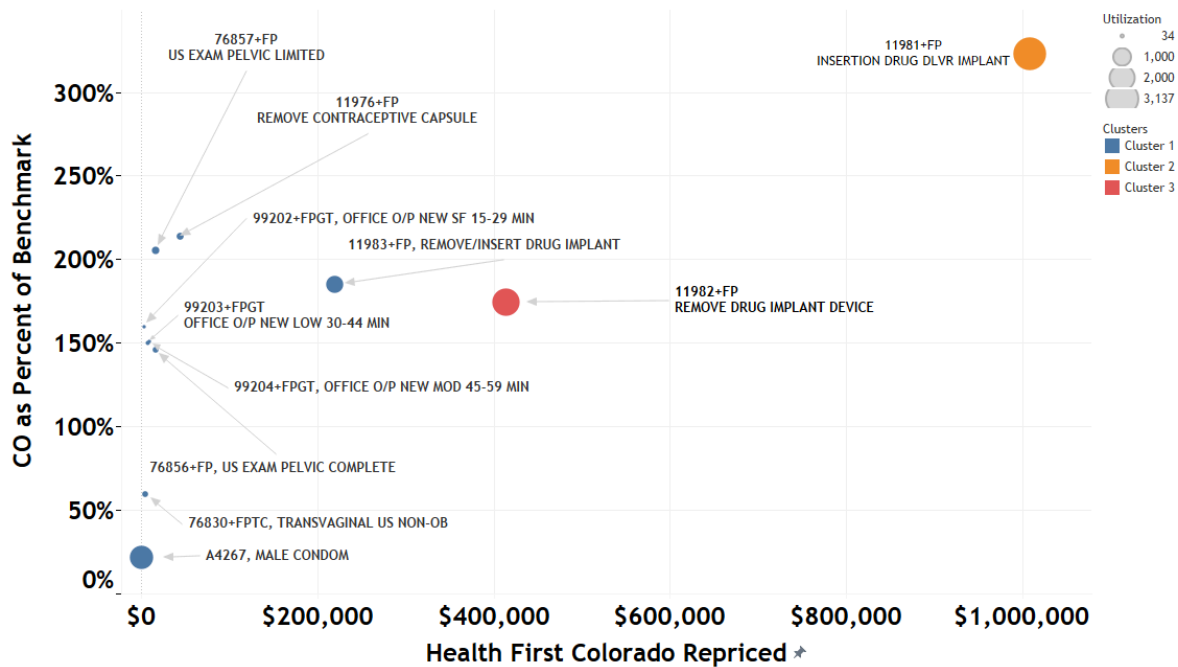


Figure 17. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Family Planning

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- Increase codes 58300 (INSERT INTRAUTERINE DEVICE) and 58301 (REMOVE INTRAUTERINE DEVICE) to 100% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$229,334 total funds, including \$62,884 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints.
- HCPF recommends increasing codes 58300 (INSERT INTRAUTERINE DEVICE) and 58301 (REMOVE INTRAUTERINE DEVICE) to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$1,143,742 total funds, including -\$313,614 General Fund.

Physician Services - Gastroenterology

Service Description

Gastroenterology services involve diagnosing and treating conditions and diseases of the digestive system. This includes conditions which impact the esophagus, stomach, intestines, liver, pancreas, or gallbladder.

A summary of the statistics for the gastroenterology service subcategory is provided below:

Physician Services - Gastroenterology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$202,599
Total Members Utilizing Services in SFY 2023-24	1,870
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-19.08%
Total Active Providers SFY 2023-24	190
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-17.03%

Table 91. Physician Services - Gastroenterology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The Gastroenterology service grouping has 59 procedure code/modifier combinations. The rates for 58 of them (98.31%) were compared to Medicare, while one combination (1.69%) is excluded due to no valid benchmark rates found.

Among these 58 codes, 35 of them (60.34%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for gastroenterology were 2.18% - 117.01%.

On average, Colorado Medicaid payments for gastroenterology are estimated at 91.21% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Gastroenterology Repriced Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Overall Repriced Benchmark Ratio
\$202,599	\$222,125	91.21%

Table 92. Comparison of Colorado Medicaid Physician Services - Gastroenterology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$19,526 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the gastroenterology panel size visual (Appendix B, Figure 135), the average number of utilizers per provider in urban and rural areas had a stable trend from SFY 2021-22 to SFY 2023-24. Additionally, the percentage of active providers that served Medicaid members was 36% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 138) shows that the percent of active providers that served only one Medicaid member increased then decreased from SFY 2021-22 to SFY 2023-24. The drive time analysis (Appendix B, Figure 139) shows that drive times were relatively high (over an hour) statewide. Finally, Colorado Medicaid had lower per utilizer per year (PUPY) expenditures and higher PUPY utilization than most payers (Appendix B, Figures 140 & 141). These findings indicate that access to care may be impacted by longer driving distances and modest provider participation.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - gastroenterology.

Physician Services - Gastroenterology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	91200	LIVER ELASTOGRAPHY	91.5%	613	28.02%
2	91200+26	LIVER ELASTOGRAPHY	96.4%	410	18.74%
3	91065+26	BREATH HYDROGEN/METHANE TEST	117.0%	172	7.86%
4	91010+26	ESOPHAGUS MOTILITY STUDY	85.1%	118	5.39%
5	91110	GI TRC IMG INTRAL ESOPH-ILE	96.2%	85	3.88%
6	91035+26	G-ESOPH REFLX TST W/ELECTROD	84.8%	84	3.84%
7	91110+26	GI TRC IMG INTRAL ESOPH-ILE	84.9%	81	3.70%
8	91122+26	ANAL PRESSURE RECORD	85.0%	74	3.38%
9	91037+26	ESOPH IMPED FUNCTION TEST	84.5%	70	3.20%
10	91010	ESOPHAGUS MOTILITY STUDY	87.2%	68	3.11%

Table 93. Physician Services - Gastroenterology top 10 procedure codes ranked by utilization

Utilization and Expenditure Trend Analysis

Due to the overall low utilization of this service, HCPF conducted an additional utilization analysis for the past five fiscal years (SFY 2019-20 - SFY 2023-24). Here is the outline of the findings shown in Figure 18:

- Utilization remained very low, with the lowest level observed in SFY 2019-20 and highest in SFY 2022-23
- Expenditures were lowest in SFY 2019-20 and reached highest level in SFY 2023-24

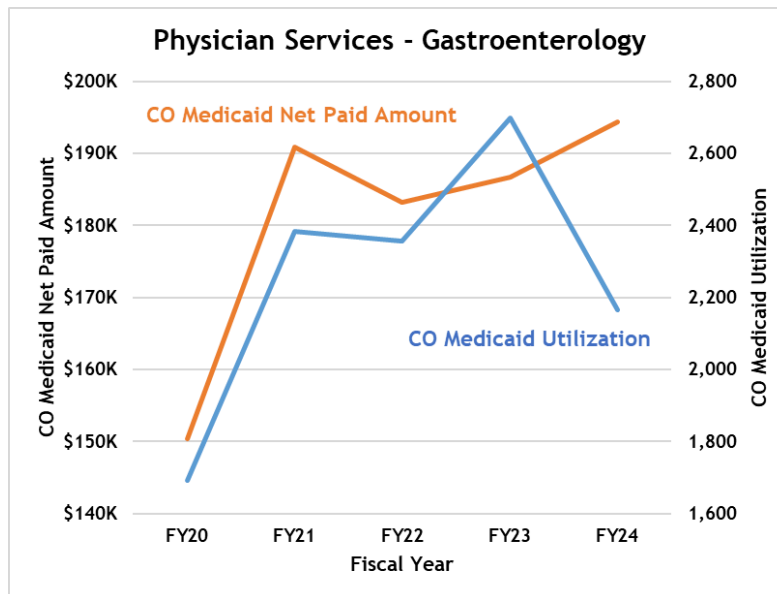


Figure 18. Physician Services - Gastroenterology CO Medicaid Utilization and Medicaid Net Paid Amount trend over SFY 2019-20 - SFY 2023-24

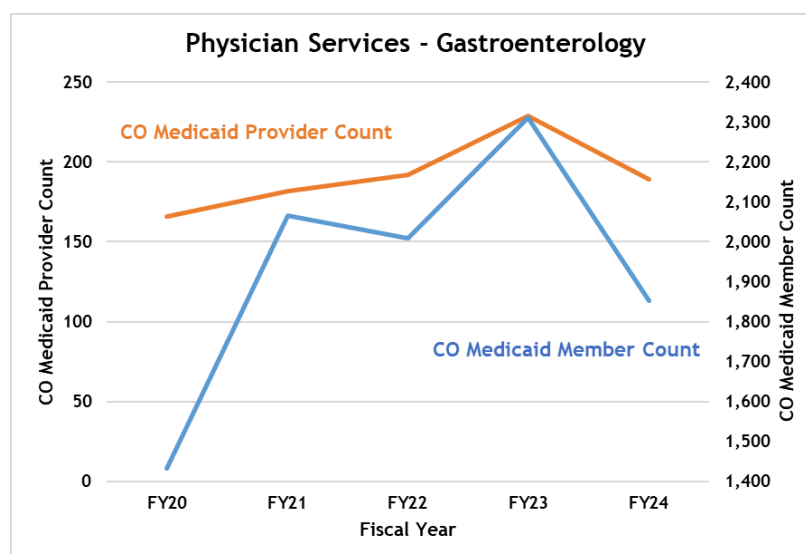


Figure 19. Physician Services - Gastroenterology CO Medicaid Member and Provider count trend over SFY 2019-20 - SFY 2023-24

Since SFY 2022-23, both the number of active Medicaid providers and Medicaid members utilizing gastroenterology services have declined (Figure 19), which may explain the reduction in utilization observed from SFY23 to SFY24. However, expenditures for this service category increased during the same period, suggesting an overall rise in the reimbursement levels.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$174 total funds, including \$48 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and to keep the rates for all codes above 80% of the benchmark the same.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$174 total funds, including \$48 General Fund.

Physician Services - Gynecology

Service Description

Gynecology is a medical specialty focused on the health of the female reproductive system. Services in this category encompass preventative care, diagnosis, treatment, surgeries and management of a broad range of related reproductive tissue conditions such as menstrual disorders, pelvic pain, endometriosis, fibroids, ovarian cysts and menopausal symptoms. Gynecologic care also includes routine screenings, such as breast cancer screening, Pap tests, and STI/HPV testing. These services are essential for maintaining reproductive and overall health throughout different stages of life, from adolescence through the post-menopausal period.

Please note:

1. All preventative codes under this subcategory will be reviewed under the Primary Care E&M subcategory.
2. Surgery codes under this subcategory will be reviewed under Surgery category in 2026.

A summary of the statistics for the gynecology service subcategory is provided below:

Physician Services - Gynecology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$1,049,434
Total Members Utilizing Services in SFY 2023-24	1,014
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-19.71%
Total Active Providers SFY 2023-24	297
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-7.76%

Table 94. Physician Services - Gynecology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The gynecology service grouping has 34 procedure code/modifier combinations. The rates for 33 of them (97.06%) were compared to Medicare, while one combination (2.94%) is excluded due to no valid benchmark rates found.

Among these 33 codes, 13 of them (39.39%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for gynecology were 65.47% - 89.75%.

On average, Colorado Medicaid payments for gynecology are estimated at 83.32% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Gynecology Repriced Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Overall Repriced Benchmark Ratio
\$1,049,434	\$1,259,488	83.32%

Table 95. Comparison of Colorado Medicaid Physician Services - Gynecology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$210,054 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the gynecology panel size visual (Appendix B, Figure 142), the average number of utilizers per provider in urban and rural areas had a stable trend from SFY 2021-22 to SFY 2023-24. The special providers visual (Appendix B, Figure 145) shows that the percentage of active providers that served only one Medicaid member decreased from SFY 2021-22 to SFY 2023-24. The drive time analysis (Appendix B, Figure 146) shows that drive times were relatively high (over an hour) in Eastern and Western Colorado. These findings indicate that access to care may be impacted by longer driving distances.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - gynecology.

Physician Services - Gynecology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	58571	TLH W/T/O 250 G OR LESS	82.8%	805	59.63%
2	58573	TLH W/T/O UTERUS OVER 250 G	84.4%	115	8.52%
3	58552	LAPARO-VAG HYST INCL T/O	84.6%	92	6.81%
4	58150	TOTAL HYSTERECTOMY	84.1%	75	5.56%

5	58570	TLH UTERUS 250 G OR LESS	84.5%	65	4.81%
6	58262	VAG HYST INCLUDING T/O	83.0%	47	3.48%
7	58260	VAGINAL HYSTERECTOMY	84.8%	37	2.74%
8	58545	LAPAROSCOPIC MYOMECTOMY	84.6%	28	2.07%
9	58542	LSH W/T/O UT 250 G OR LESS	83.2%	17	1.26%
10	58554	LAPARO-VAG HYST W/T/O COMPL	83.0%	14	1.04%

Table 96. Physician Services - Gynecology top 10 procedure codes ranked by utilization

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$98 total funds, including \$27 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and to keep the rates that are above 80% of the benchmark the same.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$65 total funds, including \$18 General Fund.

Physician Services - Health Education

Service Description

Health education services refer to services designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and/or community health. These services intended to educate members on the dangers of alcohol, nicotine, marijuana, illicit drugs, etc.

A summary of the statistics for the Health Education service subcategory is provided below:

Physician Services - Health Education Statistics	
Total Adjusted Expenditures SFY 2023-24	\$172,629
Total Members Utilizing Services in SFY 2023-24	3,667
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	47.33%
Total Active Providers SFY 2023-24	307
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-16.12%

Table 97. Physician Services - Health Education total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The health education service grouping has 6 procedure code/modifier combinations. The rate for one code (16.67%) was compared to Medicare, and the rate for one code (16.67%) was compared to rates from other states. Four codes were excluded due to no valid benchmark rates found. Individual rate ratios for health education were 74.10% - 87.12%.

On average, Colorado Medicaid payments for health education are estimated at 85.31% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Health Education Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$172,629	\$202,356	85.31%

Table 98. Comparison of Colorado Medicaid Physician Services - Health Education service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$29,727 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the health education panel size visual (Appendix B, Figure 147), the average number of utilizers per provider in urban areas increased substantially in SFY 2023-24. The telemedicine analysis (Appendix B, Figures 151 & 152) show that the percentage of health education utilizers that utilized telemedicine and the percentage of total visits that were delivered through telemedicine each increased before decreasing. The drive time analysis (Appendix B, Figure 153) shows that drive times were relatively high (over an hour) in parts of Eastern and Western Colorado. These findings indicate that access to care may be impacted by longer driving distances.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - health education.

Physician Services - Health Education Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	97535	SELF CARE MNGMENT TRAINING	87.1%	5,314	88.61%
2	96040 ²⁰	GENETIC COUNSELING 30 MIN	74.1%	683	11.39%

Table 99. Physician Services - Health Education top 10 procedure codes ranked by utilization

Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the health education service subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

²⁰ Code 96040 is a preventive code.

There are two preventive codes (33.33%) in this service grouping. One of the codes did not have valid utilization during SFY 2023-24 and no valid benchmark rates were found. The other code (96040) was compared to other states for benchmarking. However this code (96040) was terminated on 1/1/2025, and has been replaced by code 96041 (GENETIC COUNSELING SVC EA 30), a comparable service now covered under the Colorado Health First Fee Schedule, effective on 1/1/2025. The benchmark ratio was 74.10% for this code (96040), indicating a cap between Colorado's Medicaid reimbursement level and the average rate among the three benchmark states with coverage for this code. However the replacement code (96041) is reimbursed at a significantly higher rate (\$42 compared to \$30.60), resulting in a benchmark ratio of 101.72%, which suggests that the reimbursement for the replacement code is well-aligned with rates in the benchmark states.

CODE	Service Description	Utilization	% of Total Utilization	Benchmark Source
96040	GENETIC COUNSELING 30 MIN	683	11.39%	Other States
S0265	GENETIC COUNSEL 15 MINS	0	0%	N/A

Table 100. Physician Services - Health Education preventive codes analysis

Utilization and Expenditure Trend Analysis

Due to the overall low utilization of this service, HCPF conducted an additional utilization analysis for the past five fiscal years (SFY20 - SFY24). Here is the outline of the findings shown in Figure 20:

- Utilization remained very low, with the lowest level observed in SFY 2020-21 and highest in SFY 2023-24.
- Expenditures were lowest in SFY 2020-21 and reached highest level in SFY 2023-24.

Both utilization and expenditures reached their highest levels in SFY 2023-24 indicating growing demand for this service (members utilized this service increased by 47.33% compared to SFY 2022-23), and improved access within the Colorado Medicaid program.

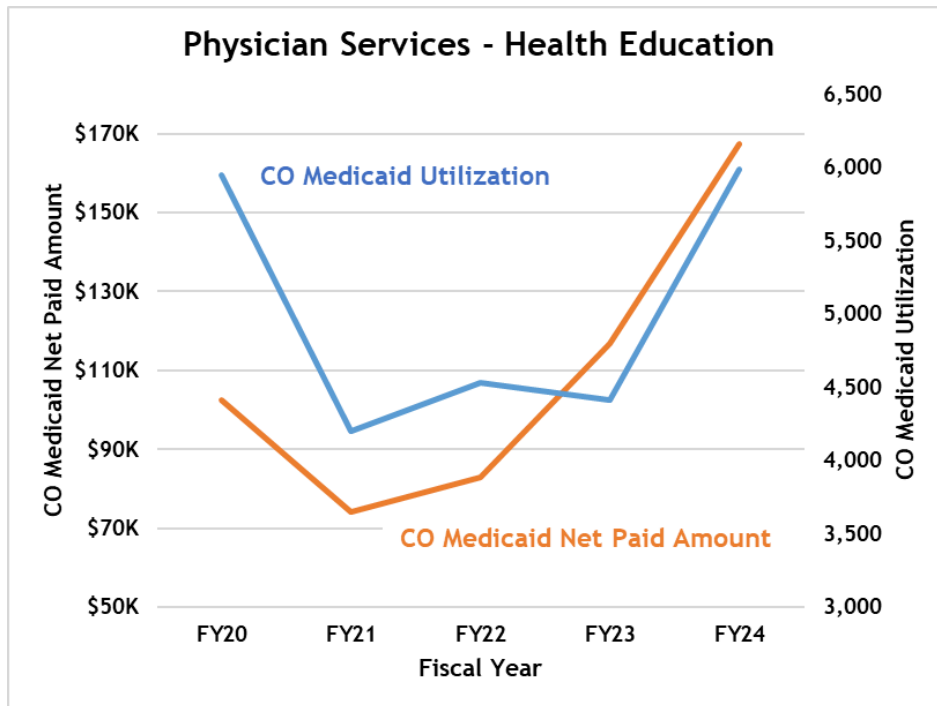


Figure 20. Physician Services - Health Education Utilization and CO Medicaid Net Paid Amount trend over SFY 2019-20 - SFY 2023-24

MPRRAC Recommendations

- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$1,409 total funds, including \$386 General Fund.

HCPF Recommendations

- HCPF recommends no change to the rates due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$0 total funds, including \$0 General Fund.

Physician Services - Medication Injections and Infusions

Service Description

Medication injections & infusions services involve administering medications directly via intravenous (IV) infusions or injections. This category also includes the usage of equipment which facilitates the administration of medications. This service category does not include services covered under Physician-Administered Drugs.

A summary of the statistics for the medication injections and infusions service subcategory is provided below:

Medication Injections & Infusions Statistics	
Total Adjusted Expenditures SFY 2023-24	2,898,719
Total Members Utilizing Services in SFY 2023-24	5,023
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.92%
Total Active Providers SFY 2023-24	1,255
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-5.00%

Table 101. medications injections & infusions total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The medication injections and infusions service grouping has 80 procedure code/modifier combinations. The rates for 34 of them (42.5%) were compared to Medicare, while the rates for eight codes (10.00%) were compared to rates from other states. Among these 42 codes, eight of them (10%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed.

Physician Services - Medication Injections & Infusions Benchmark States	
Procedure Code	Benchmark State ²¹
96376	Nebraska, Nevada, Oregon, Utah
J7330	Nevada, Oklahoma
J2513	Arizona, Oklahoma
99190, 99191, 99192	Arizona, Nebraska, Oregon, Utah
A9607	Arizona, Nebraska, Nevada, Oklahoma
A9513	Arizona, Nebraska, Oklahoma

Table 102. Physician Services - medication injections & infusions (SFY 2023-24).

Moreover, among the remaining 38 codes, 37 of them (46.25%) were excluded due to no valid benchmark rates found and additionally, they didn't have valid utilization

²¹ Please refer to the "Benchmark Rationale" provided under "Physician Services" on page 108 for benchmark rationale for all physician services.

during SFY 2023-24 either. One code was excluded because it is manually priced. Individual rate ratios for medications injections & infusions were 12.22%-267.25%.

On average, Colorado Medicaid payments for medication injections & Infusions are estimated at 112.84% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Medication Injections & Infusions Repriced Benchmark Comparison		
Colorado Repriced	Medicare and Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$2,898,719	\$2,568,867	112.84%

Table 103. Comparison of Colorado Medicaid medications injections & infusions service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$329,852 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the medication injections and infusions panel size visual (Appendix B, Figure 154), the average number of utilizers per provider in urban and rural areas had a stable trend from SFY 2021-22 to SFY 2023-24. The special providers visual (Appendix B, Figure 157) shows that the percent of active providers that served only one Medicaid member remained relatively stable. The drive time analysis (Appendix B, Figure 158) shows that drive times were relatively low statewide, although some areas in Eastern and Western Colorado were affected by higher drive times (over an hour). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the services with the highest utilization for medication injections & infusions.

Physician Services - Medication Injections & Infusions Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	J7325	SYNVISC OR SYNVISC-ONE	116.20%	15,434	33.47%
2	96375	TX/PRO/DX INJ NEW DRUG ADDON	111.40%	6,732	14.60%
3	96413	CHEMO IV INFUSION 1 HR	104.00%	6,2046	13.46%
4	96415	CHEMO IV INFUSION ADDL HR	109.00%	3,042	6.60%
5	96374	THER/PROPH/DIAG INJ IV PUSH	124.90%	2,579	5.59%
6	96401	CHEMO ANTI-NEOPL SQ/IM	90.20%	1,708	3.70%
7	96417	CHEMO IV INFUS EACH ADDL SEQ	103.00%	1,578	3.42%
8	J7321	HYALGAN SUPARTZ VISCO-3 DOSE	106.10%	1471	3.19%
9	96521	REFILL/MAINT PORTABLE PUMP	96.40%	1,238	2.69%
10	96411	CHEMO IV PUSH ADDL DRUG	100.20%	999	2.17%

Table 104. medications injections & infusions top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, one outlier with a benchmark rate less than 60% with low utilization was excluded from this service category.

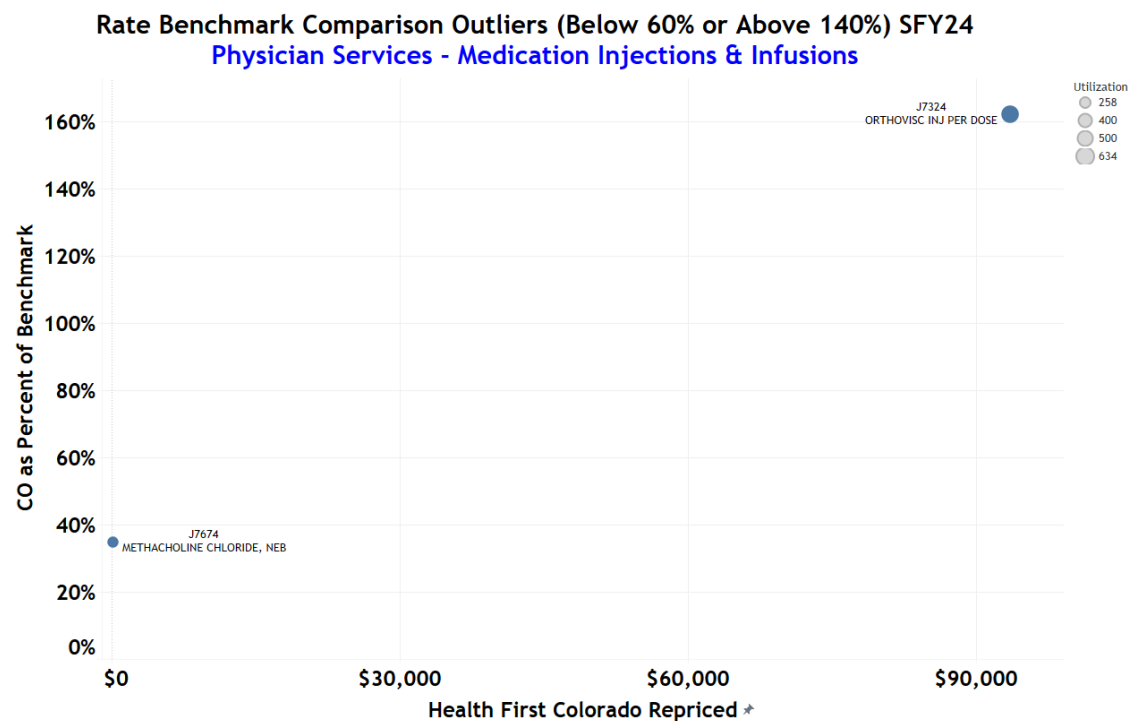


Figure 21. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - medications injections & infusions

The outlier chart above shows two small outliers, one that is more than 140% of the benchmark rate and one that is less than 60% of the benchmark rate. The two codes combined have less than 1,000 utilization and a Health First Colorado repriced amount that is less than \$100,000.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be -\$34,143 total funds, including -\$9,362 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be -\$34,143 total funds, including -\$9,362 General Fund.

Physician Services - Neuro/Psychological Testing Services

Service Description

Neuro/psychological testing services assess and diagnose a wide range of mental health and neurological conditions. This includes all types of depression screening, developmental screening, and screening for other mental health conditions.

A summary of the statistics for the Neuro/Psychological Testing Services service subcategory is provided below:

Physician Services - Neuro/Psychological Testing Services Statistics	
Total Adjusted Expenditures SFY 2023-24	\$15,248,262
Total Members Utilizing Services in SFY 2023-24	162,350
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.43%
Total Active Providers SFY 2023-24	3,581
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	26.49%

Table 105. Physician Services - Neuro/Psychological Testing Services total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The neuro/psychological testing services have 22 procedure code/modifier combinations. The rates for 15 of them (68.18%) were compared to Medicare, while the rates for two codes (9.09%) were compared to rates from other states. Among these 17 codes, one of them (5.88%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for this code. Moreover, five codes were excluded due to no valid benchmark rates found. Individual rate ratios for health education were 54.42% - 425.99%.

On average, Colorado Medicaid payments for neuro/psychological testing services are estimated at 122.21% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Neuro/Psychological Testing Services Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$15,248,262	\$12,476,717	122.21%

Table 106. Comparison of Colorado Medicaid Physician Services - Neuro/Psychological Testing Services service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$2,771,545 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the neuro/psychological testing services panel size visual (Appendix B, Figure 159), the average number of utilizers per provider in urban and rural areas had a similar pattern with downward trends. The percentage of active providers that served Medicaid members was 63% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 162) shows that the percent of active providers that served only one Medicaid member had a slight increasing trend. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

The standard methodologies for the benchmark ratio analysis is to utilize Medicare reimbursement rates when the procedure code is covered under the Medicare program. During this process for physician services - neuro/psychological testing services, HCPF identified that procedure code 96127 exhibited a significantly high benchmark ratio of 392.43%, prompting further investigation into the appropriateness of using Medicare as a benchmark for this specific code.

To better understand the context, HCPF consulted with internal policy specialists and they clarified that Medicare applies code 96127 broadly, using it for a wide range of developmental screenings across all age groups. In contrast, Colorado Medicaid applies this code more narrowly, specifically for Autism Spectrum Disorder screening, and limits its use to the pediatric and youth populations. This critical distinction in scope and target population indicated that Medicare may not serve as an appropriate benchmark for this code.

Given this input, we switched to using six other states (Arizona, Nebraska, Nevada, Oklahoma, Oregon, and Utah) for comparison, and the benchmark ratio for code 96127 dropped significantly to 152.86%.

This adjustment relates our commission to stakeholder-informed decision-making, and service-specific benchmarking, particularly when discrepancies in code utilization policies exist.

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - neuro/psychological testing services.

Physician Services - Neuro/Psychological Testing Services Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	96127	BRIEF EMOTIONAL/BEHAV ASSMT	152.9%	112,256	34.89%
2	96137	PSYCL/NRPSYC TST PHY/QHP EA	135.0%	61,941	19.25%
3	96110	DEVELOPMENTAL SCREEN W/SCORE	171.9%	50,391	15.66%
4	96133	NRPSYC TST EVAL PHYS/QHP EA	107.7%	41,449	12.88%
5	96131	PSYCL TST EVAL PHYS/QHP EA	124.9%	12,809	3.98%
6	96136	PSYCL/NRPSYC TST PHY/QHP 1ST	163.3%	11,324	3.52%
7	96132	NRPSYC TST EVAL PHYS/QHP 1ST	105.7%	10,586	3.29%
8	96139	PSYCL/NRPSYC TST TECH EA	54.4%	5,639	1.75%
9	96130	PSYCL TST EVAL PHYS/QHP 1ST	111.4%	5,024	1.56%
10	96113	DEVEL TST PHYS/QHP EA ADDL	91.3%	3,172	0.99%

Table 107. Physician Services - Neuro/Psychological Testing Services top 10 procedure codes ranked by utilization

Preventive Codes Analysis

To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to the neuro/psychological testing services subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

There are four preventive codes (18.18%) in this service grouping. One of the codes (96127) has a 152.86% benchmark ratio and was compared to other states for benchmarking, and the other three codes did not have valid benchmark rates.

CODE	Service Description	Utilization	% of Total Utilization	Benchmark Source
96127	BRIEF EMOTIONAL/BEHAV ASSMT	112,256	34.89%	Other States
G8431	POS CLIN DEPRES SCR N F/U DOC	36,465	11.33%	N/A
G8510	SCR DEP NEG, NO PLAN REQD	74,367	23.12%	N/A
G8511	SCR DEP POS, NO PLAN DOC RNG	1,200	0.37%	N/A

Table 108. Physician Services - Neuro/Psychological Testing Services preventive codes analysis

Nearly 70% of the total utilization is attributed to these four preventive codes in neuro/psychological testing services subcategory, it implies that:

- Preventive services are a primary driver of utilization within this service grouping.
- The focus of neuro/psychological testing services may be on early intervention and routine screenings, which can help reduce the need for more costly or intensive treatments later.
- Access to and uptake of preventive care appear strong, suggesting that providers and members are engaging with these services as intended by Colorado Medicaid program.
- It could also indicate that policy efforts or reimbursement strategies promoting preventive care are having their desired impact.

Year-over-Year Reimbursement Rate Trend Analysis

The neuro/psychological testing services subcategory has an overall benchmark ratio of 122.21%, indicating that Colorado Medicaid reimbursement exceeds Medicare benchmarks on average. To better understand this high benchmark ratio, HCPF conducted a year-over-year reimbursement rate percentage changes analysis across all 15 procedure code and modifier combinations using Medicare for benchmarking. 11 of these 15 codes have a benchmark ratio above 100%, with nine of them showing utilization in SFY 2023-24.

As shown in Figure 22:

- Over the 4-year time period from 2021-2025²², Medicare rates for all these 15 codes declined by an average of 6.68%, while Colorado Medicaid rates increased by an average of 17.79%. The divergence in rate trends has resulted in an elevated overall benchmark ratio, calculated as Colorado's repriced amount divided by Medicare's repriced amount.
- From 2021 to 2022, there was a significant increase in Colorado Medicaid rates. This change was primarily driven by two codes, and likely due to targeted rate adjustments:
 - 96105: ASSESSMENT OF APHASIA (85% increase, current benchmark ratio: 92.20%)
 - 96125: COGNITIVE TEST BY HEALTH CARE PROFESSIONAL (48% increase, current benchmark ratio: 93.40%)

²² “Over the 4-year time period from 2021-2025” refers to the span during which annual rate changes were analyzed. The rate change calculations are conducted between each pair of consecutive years (i.e., 2021-2022, 2022-2023, etc.) across this period. (1) Medicare rates are assessed on a calendar year basis (January-December); (2) Medicaid rates are assessed on a fiscal year basis (July-June).

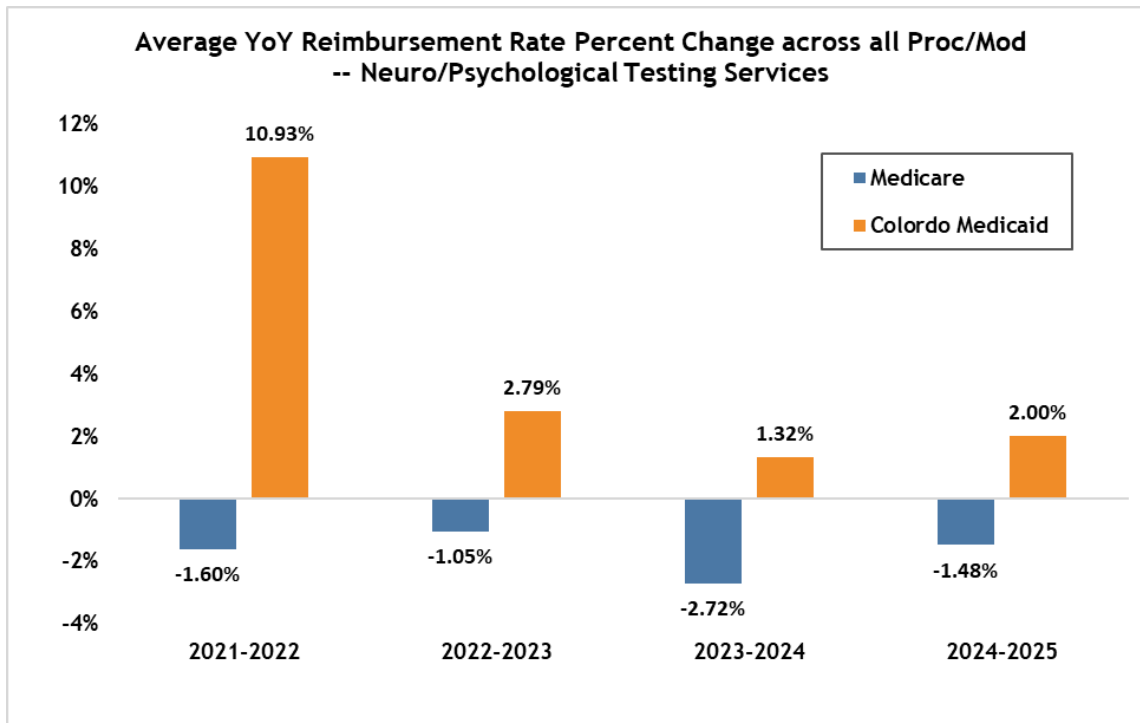


Figure 22. Bar chart indicating the average year-over-year Physician Services - Neuro/Psychological Testing Services reimbursement rate percentage changes for Medicare and Colorado Medicaid

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate.

As shown in the bubble chart below (Figure 23) for neuro/psychological testing services, one procedure code (96139) was reimbursed at less than 60% of the benchmark, and four codes (96127, 96136, 96110, and 96146) were reimbursed at more than 140% of the benchmark, ranging between 153% - 426%.

Among all five outliers:

- Code 96127 had the highest utilization, with over 112,000 allowed units, accounting for 34.89% of total utilization in this service group. This code also represented the highest expenditure, slightly above \$2 million (13.53% of the total).
- Code 96146 exhibited the highest benchmark ratio of 426%. However it accounted for the lowest utilization, with 5,639 allowed units (0.27% of the total). Additionally, it had the smallest Colorado repriced amount, totaling \$8,440 (0.06% of the total).

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - Neuro/Psychological Testing Services

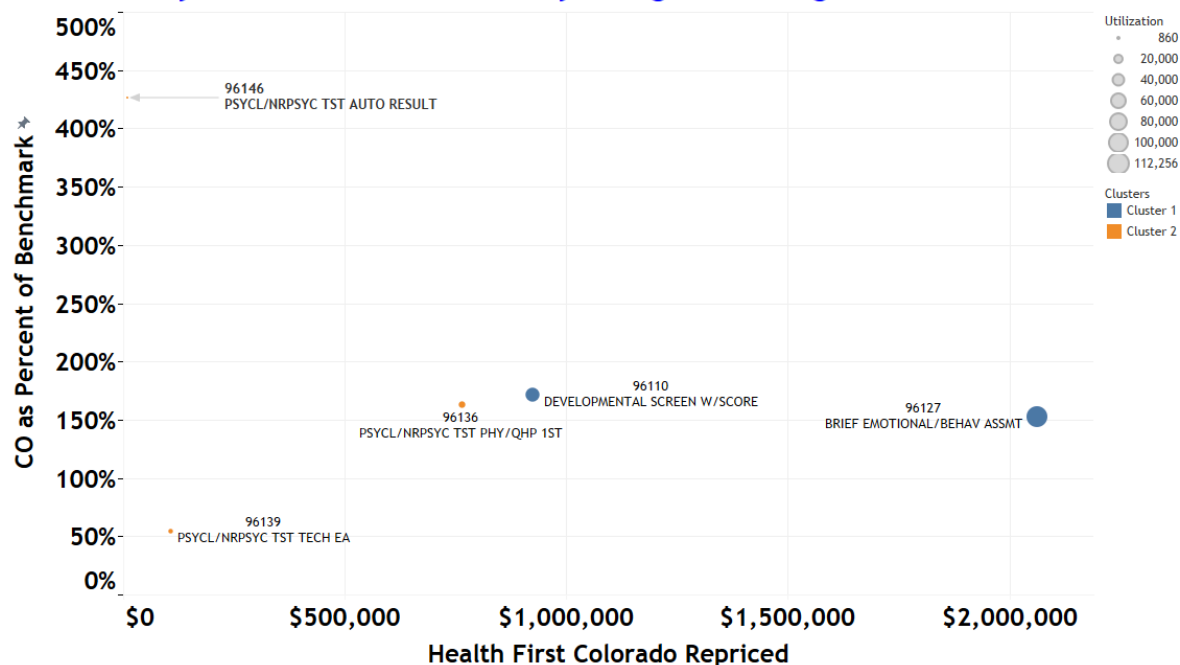


Figure 23. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Neuro/Psychological Testing Services

MPRRAC Recommendations

- For codes with benchmark ratio, the MPRRAC recommends increasing rates under 100% of the benchmark and compared to Medicare to 100% of the benchmark.
- MPRRAC recommends aligning reimbursements for certain evaluation and testing codes so that the rates for the second hour (and beyond) match the corresponding first-hour codes. Specifically, this includes aligning 96131 with 96130, 96133 with 96132, 96137 with 96136, 96139 with 96138, and 96113 with 96112.
- For codes with valid Colorado rate but without benchmark ratios, MPRRAC recommends aligning the rates of codes with modifiers to the rates of the same codes without modifiers (96110EP to 96110 and 96116GT to 96116). And for G-Codes (G8431, G8510, and G8511), MPRRAC recommends increasing the rates by 10%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$3,818,091 total funds, including \$1,046,921 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints. However, HCPF recommends keeping the rate for code 96127 the same.
- HCPF recommends swapping the rates for code 96110 and code 96110 with the EP modifier to reflect the difference between the first and second screenings.
- For the three G-codes (G8431, G8510, and G8511) with valid Colorado rate but without benchmark ratios, HCPF recommends 10% of increase.
- For code 96116 with GT modifier which has a valid Colorado rate but without benchmark ratio, HCPF recommends no change. Please refer to GT Modifier Justification mentioned at Outpatient Speech-Language Therapy (ST) Services for more details (page 86).
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$1,553,220 total funds, including -\$425,893 General Fund.

Policy Justification

HCPF does not recommend aligning reimbursement rates for psychological and neuropsychological testing codes so that second-hour services match first-hour services. The Relative Value Units (RVUs) for these codes intentionally differ because the first hour of evaluation involves higher-intensity activities such as record review, test selection, data integration, and initiation of documentation. Subsequent hours reflect a continuation of testing tasks at a lower intensity of provider work. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) structured these codes to reflect this difference, and aligning Medicaid rates would place Colorado out of step with national standards and complicate cross-payer alignment. Equalizing payment across first and subsequent hours could also create unintended incentives for extending testing time, resulting in higher program costs without clear benefits to members. Maintaining differential payment ensures that providers are appropriately compensated for both the initial and ongoing components of evaluation, while supporting network adequacy and member access.

Please refer to page 87 of Speech Therapy section for a detailed explanation of the GT modifier.

Physician Services - Neurology

Service Description

Neurology involves the diagnosis, treatment, and management of disorders affecting the nervous system, including the brain, spinal cord, and peripheral nerves. Neurological services encompass a wide range of conditions such as epilepsy, stroke, multiple sclerosis, Parkinson's disease, migraines, and neuropathies. Providers in this category include neurologists and other specialists who utilize clinical evaluations, diagnostic testing (e.g., electroencephalograms, electromyography testings, imaging), and therapeutic interventions to support patients with acute and chronic neurological conditions.

A summary of the statistics for the Neurology service subcategory is provided below:

Physician Services - Neurology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$5,093,482
Total Members Utilizing Services in SFY 2023-24	13,366
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.68%
Total Active Providers SFY 2023-24	627
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	1.29%

Table 109. Physician Services - Neurology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The Neurology service grouping has 237 procedure code/modifier combinations. The rates for 203 of them (85.65%) were compared to Medicare, while the rates for eight codes (3.38%) were compared to rates from other states. When comparing procedure code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

Physician Services - Neurology Benchmark States	
Procedure Code	Benchmark State ²³
95965	Nebraska, Nevada, Oklahoma, and Utah
96003	Arizona, Nebraska, Nevada, Oklahoma, and Oregon
95965+TC, 95966+TC, 95966, 95967+TC, and 95967	Nebraska, Nevada, and Oklahoma
96020	Arizona, and Nevada

Table 110. Physician Services - Neurology Benchmark States (SFY 2023-24).

²³ Please refer to the “Benchmark Rationale” provided under “Physician Services” on page 108 for benchmark rationale for all physician services.

Among these 211 codes, 89 of them (42.18%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, 26 combinations (10.97%) were excluded due to no valid benchmark rates found. Individual rate ratios for Neurology were 0.29% - 367.04%.

On average, Colorado Medicaid payments for Neurology are estimated at 93.91% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Neurology Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$5,093,482	\$5,423,652	93.91%

Table 111. Comparison of Colorado Medicaid Physician Services - Neurology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$330,170 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the neurology panel size visual (Appendix B, Figure 164), the average number of utilizers per provider in urban and rural areas were stable. The special providers visual (Appendix B, Figure 167) shows that the percent of active providers that served only one Medicaid member was stable. These findings indicate that access to care is stable. The drive time analysis (Appendix B, Figure 168) shows that parts of Eastern and Western Colorado had relatively high drive times (over an hour). These findings indicate that access to care may be impacted by differential availability of providers, but is otherwise stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - Neurology.

Physician Services - Neurology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	95886	MUSC TEST DONE W/N TEST COMP	88.5%	4,902	14.32%
2	95720	EEG PHY/QHP EA INCR W/VEEG	116.4%	4,100	11.98%
3	95700	EEG CONT REC W/VID EEG TECH	107.7%	1,453	4.24%
4	95718	EEG PHYS/QHP 2-12 HR W/VEEG	115.5%	1,323	3.86%
5	95938+26	SOMATOSENSORY TESTING	87.2%	1,164	3.40%
6	95819+26	EEG AWAKE AND ASLEEP	84.6%	1,143	3.34%
7	95886+26	MUSC TEST DONE W/N TEST COMP	94.6%	1,102	3.22%
8	95715	VEEG EA 12-26HR INTMT MNTR	51.0%	1,070	3.13%
9	95910	NRV CNDJ TEST 7-8 STUDIES	93.2%	886	2.59%
10	95813+26	EEG EXTND MNTR 61-119 MIN	106.0%	829	2.42%

Table 112. Physician Services - Neurology top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, 11 outliers with low utilization were excluded from this service category; 10 of these were outliers with benchmark ratios below 60%, and one of these was outliers with benchmark ratios above 140%.

The bubble chart below (Figure 24) indicates that there are four outliers displayed for neurology service grouping:

- Two outliers, 95822+26, and 95715, have benchmark ratios 25.27% and 50.96%. Their repriced amounts are \$1,520 (0.03% of the total) and \$563,951 (11.07% of the total), and their utilization amounts are 110 (0.32% of the total) and 1,070 (3.13% of the total) allowed units, respectively.
- Two outliers, 95714, and 95708, have benchmark ratios 258.07% and 342.11%. Their repriced amounts are \$107,210 (2.10% of the total) and \$246,613 (4.84% of the total), and their utilization amounts are 204 (0.60% of the total) and 467 (1.36% of the total) allowed units, respectively.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - Neurology

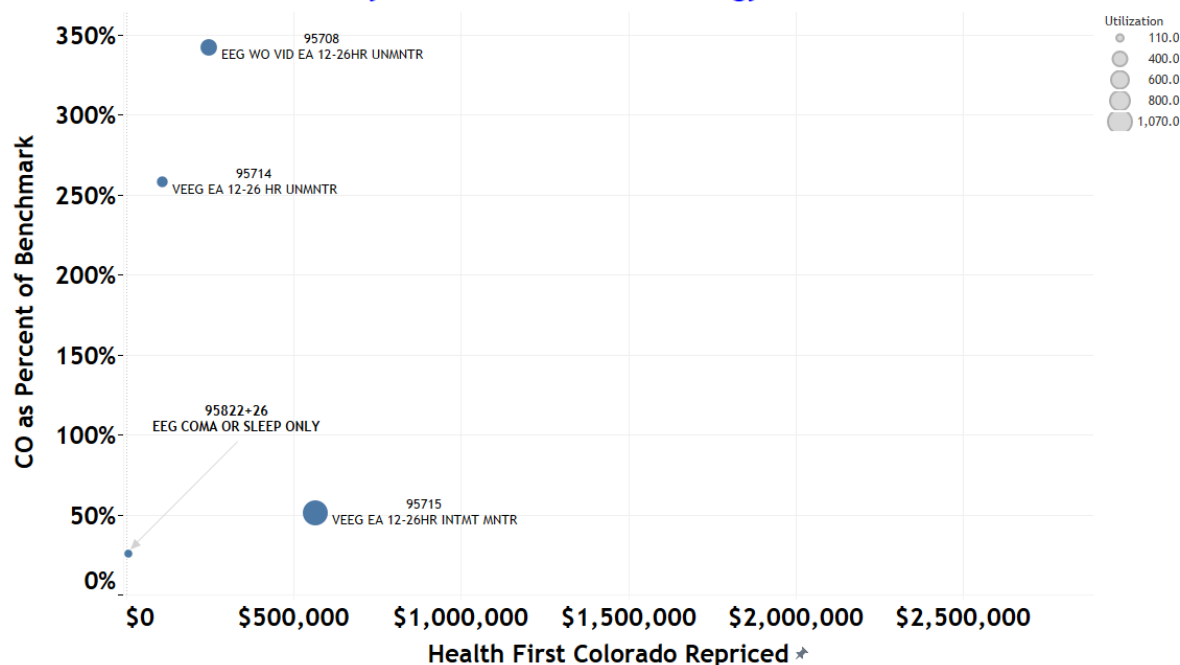


Figure 24. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Neurology

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$113,980 total funds, including \$31,253 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$135,536 total funds, including -\$37,164 General Fund.

Physician Services - Primary Care Evaluation and Management (E&M)

Service Description

Primary care E&M services include basic office visits available to all Health First Colorado (CO) members that involve diagnosing and treating a patient's health. These encounters can lead to members being referred to specialists for additional services.

A summary of the statistics for the primary care E&M service subcategory is provided below:

Physician Services - Primary Care E&M Statistics	
Total Adjusted Expenditures SFY 2023-24	\$286,827,928
Total Members Utilizing Services in SFY 2023-24	666,434
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-8.36%
Total Active Providers SFY 2023-24	18,494
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-1.36%

Table 113. Physician Services - Primary Care E&M total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The primary care E&M service grouping has 142 procedure code/modifier combinations. The rates for 103 of them (72.54%) were compared to Medicare, while the rates for 35 codes (24.65%) were compared to rates from other states. Among these 138 codes, 32 of them (23.19%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, four combinations (2.82%) are excluded due to no valid benchmark rates found. Individual rate ratios for primary care E&M were 31.53% - 240.64%.

On average, Colorado Medicaid payments for primary care E&M are estimated at 87.26% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Primary Care E&M Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$286,827,928	\$328,723,440	87.26%

Table 114. Comparison of Colorado Medicaid Physician Services - Primary Care E&M service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$41,895,512 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the primary care E&M panel size visual (Appendix B, Figure 169), the average number of utilizers per provider in urban areas had a downward trend in SFY 2023-24. The penetration rate visual (Appendix B, Figure 171) shows that utilization per 1000 members was moderately high statewide. The percentage of active providers that served Medicaid members was approximately 73% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 172) shows that the percent of active providers that served only one Medicaid member remained stable. The telemedicine analysis (Appendix B, Figures 173 & 174) shows that the percentage of individual members that utilized primary care E&M telemedicine services decreased, while the percentage of total primary care E&M visits that were delivered through telemedicine increased. Finally, the drive time analysis (Appendix B, Figure 175) shows that drive times were relatively low statewide. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

To ensure a comprehensive understanding of how Colorado Medicaid's primary care E&M service compares to Medicare, benchmark states, and selected commercial plans, we conducted a series of analyses targeting preventive care and well-child visits. Throughout this process, we collaborated closely with key stakeholders to ensure accurate interpretation and contextualization of the data. Internally, we engaged the following teams:

- Policy specialists from the Primary Care team in the Health Policy Office, who offered insight into code categorization, program intent, and contextual factors affecting service delivery
- The Payment Reform team in the Finance Office, which provided commercial rate data and recommended to incorporate American Academy of Pediatrics (AAP) rates for benchmarking when Medicare rates were not available for well-child visit codes
- The Provider Performance team in the Cost Control & Quality Improvement Office, which shared their SQL scripts and results that were used to confirm our well-child analyses logic and outcome

These internal collaborations were essential to ensure the analysis was data-driven and informed by policy and operational considerations. For additional analysis details, please refer to the "Additional Research" section of this report.

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - primary care E&M.

Physician Services - Primary Care E&M Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	99214	OFFICE O/P EST MOD 30-39 MIN	83.2%	833,080	28.17%
2	99213	OFFICE O/P EST LOW 20-29 MIN	82.7%	673,448	22.77%
3	99215	OFFICE O/P EST HI 40-54 MIN	83.1%	190,483	6.44%
4	99204	OFFICE O/P NEW MOD 45-59 MIN	82.2%	188,336	6.37%
5	99203	OFFICE O/P NEW LOW 30-44 MIN	92.4%	169,134	5.72%
6	99214GT	OFFICE O/P EST MOD 30-39 MIN	112.6%	116,214	3.93%
7	99391	PER PM REEVAL EST PAT INFANT	98.6%	68,800	2.33%
8	99212	OFFICE O/P EST SF 10-19 MIN	83.8%	62,334	2.11%
9	99417	PROLNG OP E/M EACH 15 MIN	167.9%	59,755	2.02%
10	99392	PREV VISIT EST AGE 1-4	98.8%	59,095	2.00%

Table 115. Physician Services - Primary Care E&M top 10 procedure codes ranked by utilization

Preventive Codes Analysis

Primary care serves as the foundation of an effective and sustainable healthcare system, offering both improved patient outcomes and significant cost savings. This analysis highlights how investments in primary care—particularly through preventive services and innovative care models—drive measurable benefits across public programs.

Preventive care boosts positive patient outcomes. Participation in the Medicare Shared Savings Program (MSSP) by primary care physicians has been linked to increased delivery of key preventive services, including vaccinations, depression screenings, tobacco use assessments, and wellness visits.²⁴ Additionally, in 2023, Medicare ACOs generated \$2.1B in net savings with higher savings tied to greater

²⁴ Huang, H., Zhu, X., & Wehby, G. L. (2022). Primary care physicians' participation in the Medicare shared savings program and preventive services delivery: Evidence from the first 7 years. *Health services research*, 57(5), 1182-1190. Retrieved from <https://doi.org/10.1111/1475-6773.14030>

primary care physician participation.²⁵ Personalized prevention reduces acute care use. Personalized preventive care through the MDVIP model for Medicare Advantage patients led to notable reductions in emergency room visits and inpatient admissions, resulting in monthly per-patient savings.²⁶ Lastly, chronic disease prevention could yield significant savings for public spending. A 5% reduction in chronic disease prevalence, such as diabetes and hypertension, could yield annual savings of \$9 billion in the short term and up to \$24.7 billion over the long term, with the greatest relative benefit seen in Medicaid and Medicare.²⁷

Significant analyses were performed on primary care for the 2025 MPRRAC review cycle due to its impact on patient care and cost savings. To better understand service utilization and identify potential gaps in care, HCPF conducted an analysis of preventive codes specific to primary care E&M service subcategory. Preventive services play a critical role in reducing the need for more complex procedures.

There are 35 preventive codes (25%) in this service grouping and the benchmark ratio range is 71.39% - 112.06%, 15 of these 35 codes (42.86%) use Medicare for benchmarking.

	Utilization	CO Repriced	Utilizer Count
Preventive Codes	414,821	\$33,621,878	273,680
All Primary Care E&M Codes	2,958,007	\$286,827,928	666,4734
Percentage of Preventive Codes Over All Primary Care E&M Codes	14%	12%	41%

Table 116. Physician Services - Primary Care E&M preventive codes analysis

Well-Child Utilization Analysis, Age 0 -17 years

Well-child visits are critical for monitoring child development, administering immunizations, and addressing potential health issues early. This analysis helps assess how effectively the Medicaid population is accessing these preventive services,

²⁵ Morken, I., Brown, K., Bonesteel, R., Muhlestein, D., McStay, F., & Saunders, R. (2025). Medicare accountable care organizations in 2023: Large savings with increasing value-based programmatic competition. *Health Affairs Forefront*. Retrieved from <https://www.healthaffairs.org/content/forefront/medicare-accountable-care-organizations-2023-large-savings-increasing-value-based>

²⁶ Musich, S., Klemes, A., Kubica, M. A., Wang, S., & Hawkins, K. (2014). Personalized preventive care reduces healthcare expenditures among Medicare Advantage beneficiaries. *The American journal of managed care*, 20(8), 613-620. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/25295675/>

²⁷ Ormond, B. A., Spillman, B. C., Waidmann, T. A., Caswell, K. J., & Tereshchenko, B. (2011). Potential National and state medical care savings from Primary Disease Prevention. *American Journal of Public Health*, 101(1), 157-164. Retrieved from <https://doi.org/10.2105/ajph.2009.182287>

identify disparities by age and geography, and inform efforts to improve outreach and utilization.

The base population used for this analysis is SFY 2023-24 Colorado Medicaid-Only Fee-For-Service (FFS) members aged 0 to 17 years. Within this population, 14% reside in rural areas and 86% in urban areas. This population closely mirrors the overall state pattern, as approximately 14% of Colorado's total population lives in rural areas²⁸. This representative split supports the validity of the findings and indicates that while urban-focused efforts will impact the majority of children, rural access issues must still be addressed to ensure equitable preventive care across the state.

As shown in Figure 25, overall, 60% of members aged 0 - 17 years received well-child visits in SFY 2022-23 and SFY 2023-24. Children aged 0 - 2 years had a much higher utilization rate of 82%, compared to only 54% among those aged 3 - 17.

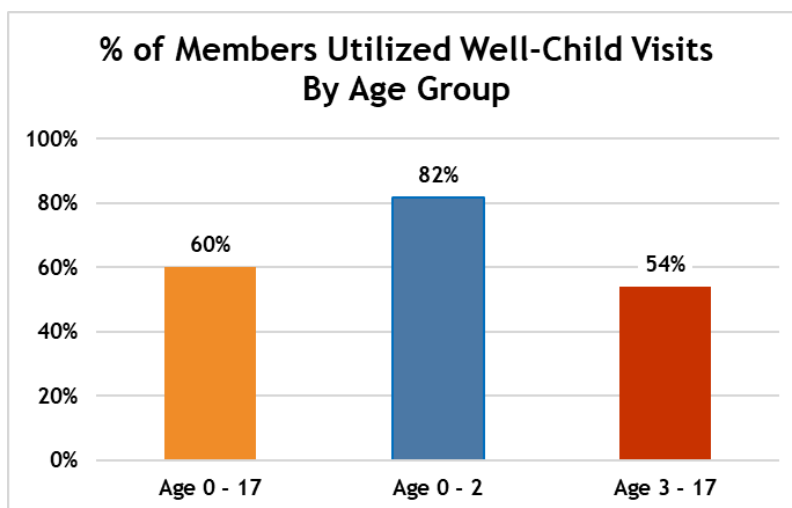


Figure 25. Bar chart indicating the utilization rate among Colorado Medicaid FFS members (Ages 0-17) in SFY2023-24 with a well-child visit in SFY 2022-23 and SFY 2023-24, by Age Group, for Physician Services - Primary Care E&M Services

Regionally, for children aged 0 - 2, the utilization rates for rural and urban areas are 77% and 83% respectively. However, among children aged 3 to 17, the rates are much lower with rural rate at 48%, and urban rate at 55%. This information can be found in Figure 26 below.

²⁸ Rural population in Colorado can be found at https://www.americashealthrankings.org/explore/measures/pct_rural_b/CO

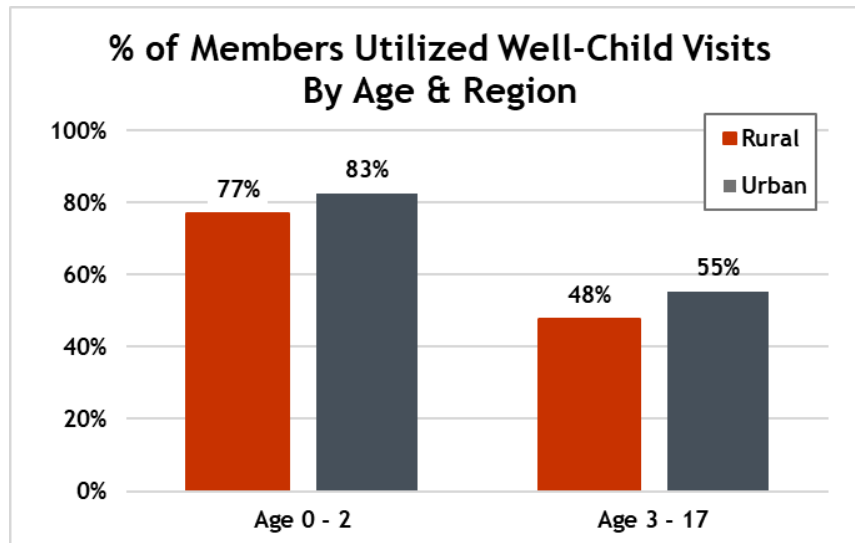


Figure 26. Bar chart indicating the utilization rate among Colorado Medicaid FFS members (Ages 0-17) in SFY 2023-24 with a well-child visit in SFY 2022-23 and SFY 2023-24, by Age Group and Region, for Physician Services - Primary Care E&M Services

The data show strong adherence to preventive visit schedules among infants and toddlers, but a sharp decline in utilization for older children, especially in rural communities. These trends suggest a need for targeted efforts to increase engagement with preventive care among families of older children, particularly in rural areas.

Well-Child Utilization Analysis, Age 16 -30 months

Ages 16 to 30 months represent a vital developmental stage where multiple well-child visits are recommended for screening and early intervention. This analysis evaluates how well children in this age group are served within Colorado's Medicaid and Child Health Plan Plus (CHP+) programs. Data from the Center for Improving Value in Health Care (CIVHC) for this age group is also included in this analysis for two reasons: first, to cross-validate the Medicaid utilization rates with an external data source; and second, to compare Medicaid and commercial utilization, highlighting any disparities in preventive care between these two populations.

The base population used for this analysis is SFY 2022-23 Colorado Medicaid and CHP+ members aged 16 to 30 months, across both FFS and Managed Care models. Within this population, 14% reside in rural areas and 86% in urban areas.

As shown in Figure 27, 71% of rural children aged 16 - 30 months received at least one well-child visit. When evaluating children who received two or more visits, the rates dropped to 52% in rural areas and 58% in urban areas. Compared to calendar year 2020

data from CIVHC²⁹, which reported a 75% utilization rate among commercial payers and 57% among CO Medicaid payers in rural settings, CO Medicaid performance aligns closely with historical Medicaid norms but lags behind commercial benchmarks.

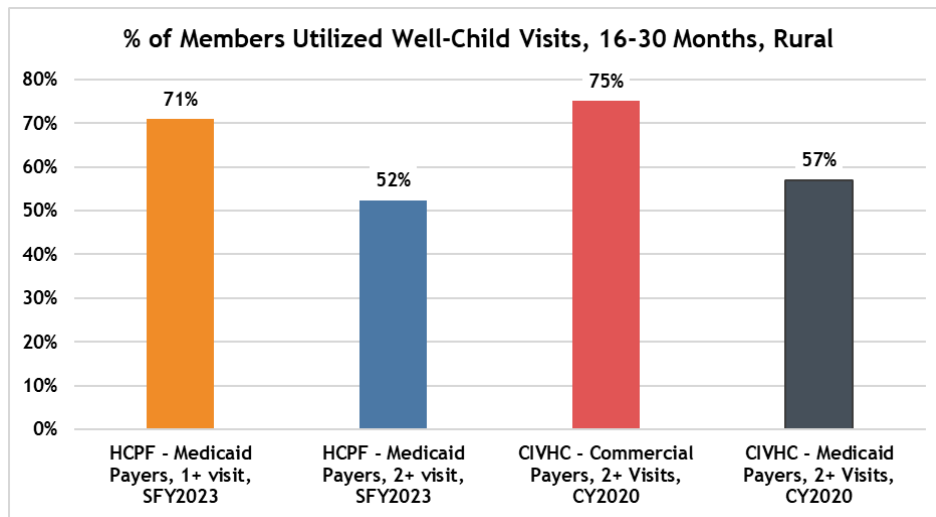


Figure 27. Bar chart indicating the utilization rates among Colorado Medicaid and CHP+ Members (Ages 16-30 months) in SFY 2022-23, by Region and Visit Frequency, with comparison to CIVHC data, for Physician Services - Primary Care E&M Services

While most of the children in this age group received at least one well-visit, fewer completed the recommended subsequent visits. The slightly lower performance in rural areas and the gap with commercial payers highlight the importance of reinforcing access and education for caregivers during this key developmental state.

Well-Child Visit Codes Rate-Only Comparison

Adequate provider reimbursement is a key factor in ensuring access to preventive pediatric care. This analysis reviews how CO Medicaid's payment levels for eight well-child visit codes compared with benchmark states³⁰, the American Academy of Pediatrics (AAP) recommendations³¹, and average of commercial plans³². The goal is to

²⁹ CIVHC data can be found at <https://civhc.org/2022/04/29/data-dive-pediatric-care-in-colorado>

³⁰ Medicare rates for these eight well-child visit codes are not available.

³¹ AAP rates were calculated based on the document downloaded from <https://downloads.aap.org/AAP/PDF/2022%20BRVS.pdf>.

³² KPMG downloaded commercial rates published by commercial insurers in accordance with the Transparency in Coverage regulations (85 FR 72158 (2020)) in September 2024 and shared them with HCPF.

assess the adequacy of current rates and identify areas where improvements may be needed.

As shown in Figure 28, across eight well-child visit codes analyzed, the average CO Medicaid reimbursement rate equaled 98% of the average of six benchmark state rates, indicating near-parity. Compared to AAP recommended rates, CO Medicaid reimbursement averaged 86%. However, CO Medicaid reimbursement rates are substantially lower than those of commercial payers, averaging only 55%.

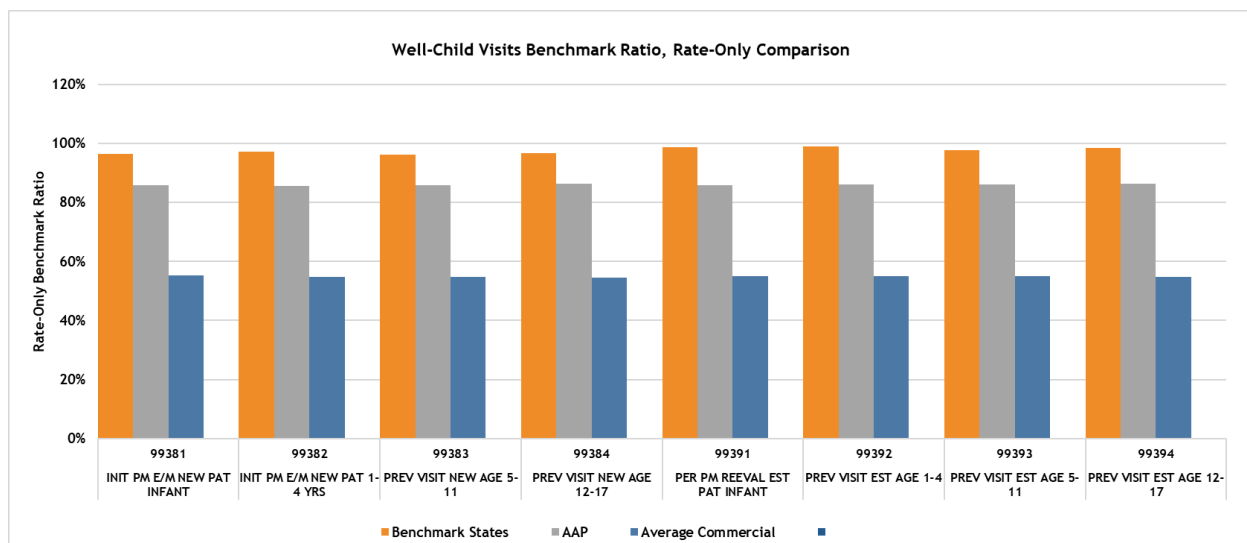


Figure 28. Bar chart indicating the benchmark ratio for eight well-child visit codes against benchmark states, AAP recommendations, and the average of commercial plans for Physician Services - Primary Care E&M Services

Table 117 provides code-level reimbursement rates for eight well-child visit codes across Colorado Medicaid, benchmark states, AAP recommendations, and five commercial payers.

Physician Services - Primary Care E&M Well-Child visit codes' Benchmark Rates Across Payers									
Code	Service Description	Colorado Medicaid (202407)	Benchmark States	AAP	United HC POS	United HC Choice POS	United HC PPO	Kaiser KFHP	Anthem BCBS PPO
99381	INIT PM E/M NEW PAT INFANT	\$95.70	\$99.22	\$111.70	\$163.49	\$207.29	\$169.87	\$174.99	\$152.05
99382	INIT PM E/M NEW PAT 1-4 YRS	\$99.91	\$102.85	\$116.73	\$171.51	\$217.27	\$178.21	\$184.87	\$159.25
99393	PREV VISIT NEW AGE 5-11	\$103.94	\$108.19	\$121.13	\$178.26	\$225.71	\$185.23	\$193.68	\$165.97
99384	PREV VISIT NEW AGE 12-17	\$117.02	\$120.95	\$135.61	\$201.10	\$255.79	\$208.98	\$222.12	\$187.55

99391	PER PM REEVAL EST PAT INFANT	\$86.06	\$87.29	\$100.40	\$146.85	\$186.72	\$152.57	\$158.26	\$137.18
99392	PREV VISIT EST AGE 1-4	\$91.96	\$93.04	\$106.79	\$156.73	\$198.74	\$162.84	\$170.49	\$146.30
99393	PREV VISIT EST AGE 5-11	\$91.66	\$93.83	\$106.44	\$156.18	\$198.09	\$162.27	\$170.32	\$145.82
99394	PREV VISIT EST AGE 12-17	\$100.42	\$101.91	\$116.23	\$171.59	\$217.58	\$178.30	\$189.20	\$160.21

Table 117. Physician Services - Primary Care E&M well-child visit codes' benchmark rates across payers

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, two outliers with low utilization were excluded from this service category, and both of them have benchmark ratios under 60%.

The bubble chart below (Figure 29) indicates that there are four procedure codes reimbursed at less than 60% of the benchmark and six codes reimbursed at more than 140% of the benchmark displayed for primary care E&M service grouping. These ten outliers are grouped into three clusters:

- Cluster 1 includes four outliers, procedure codes 99070, 99401, 99415, and 99050, with benchmark ratio ranging between 3.15% - 46.43%. Their repriced amounts range between \$3,105 to \$504,571 (0.18% of the total), and their utilization ranges from 83 - 17,407 (0.59% of the total) allowed units. Overall, cluster 1 contains outliers with benchmark ratios below 60%.
- Cluster 2 includes five procedure codes 99404, 99403, 99402, 99304, and 99409, with benchmark ratio ranging between 142.78% and 197.82%. Their repriced amounts range between \$2,457 to \$116,561 (0.04% of the total), and their utilization ranges from 42 - 2,112 (0.07% of the total) allowed units. Overall, cluster 2 contains outliers with benchmark ratios above 140%, low utilization, and lower repriced amount.
- Cluster 3 includes one procedure code 99417, with benchmark ratio at 167.85%. The repriced amount is \$2,597,754 (0.91% of total), and the utilization amount is 59,755 allowed units (2.024% of the total). This outlier has the highest utilization and repriced amount among all identified outliers.

Rate Benchmark Comparison Outliers (Below 60% or Above 140%) SFY24 Physician Services - Primary Care and Evaluation & Management Services

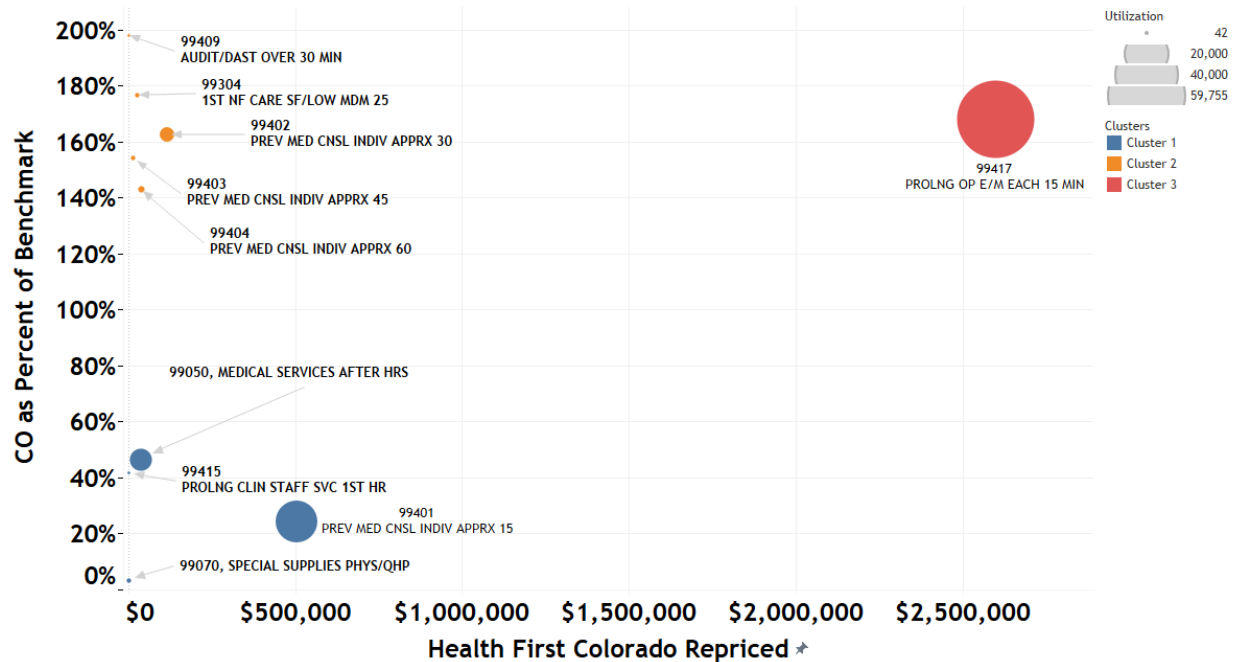


Figure 29. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Primary Care E&M

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends:
 - Increasing rates under 80% of the benchmark to 80% of the benchmark.
 - Increase pediatric and adult well-visit codes to 100% of the benchmark
 - Increase codes related to cervical cancer, and DXA scans to 100% of the benchmark
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The MPRRAC made the following policy recommendations. Currently, there is no estimate of fiscal impact tied to these recommendations:
 - Look into telehealth premiums and re-evaluate for parity.
 - For codes with benchmark ratios, use code G2211 as a marker to identify services being offered in primary care settings, to incentivize or enhance those payments.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$969,652 total funds, including \$265,879 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark and decreasing the rates above 100% of the benchmark to 100% of the benchmark due to budget constraints.
- HCPF recommends increasing pediatric and adult well-visit codes to 100% of the benchmark. These codes are: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, and 99395.
- HCPF recommends increasing codes related to cervical cancer, and DXA scans to 100% of the benchmark. These codes are: 77080, 77080+26, 77080+TC, 77081, 77081+26, 77086, 88141, 88142, 88164, 88175, G0143, G0145, Q0091, 77081+TC, 77086+26, 77086+TC, 88143, 88147, 88148, 88150, 88152, 88153, 88165, 88166, 88167, 88174, G0123, G0124, G0141, G0144, G0147, G0148, P3000, and P3001.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$2,594,476 total funds, including -\$711,405 General Fund.

Policy Justification

The Department carefully reviewed the MPRRAC committee's recommendation to use code G2211 as a marker to identify and incentivize primary care services. This code has been analyzed in April 2025 and the Department does not recommend coverage for G2211. The primary concern is the significant fiscal impact, estimated at more than \$95 million in the first year of implementation, with nearly \$30 million attributable to the General Fund (see Recommendation G2211 Services_eClearance final.pdf, Appendix F2). In addition, the intended purpose of G2211—recognizing the complexity and longitudinal role of primary care—is already addressed through the Accountable Care Collaborative (ACC) Phase III framework and payments administered by the Regional Accountable Entities (RAEs). These existing value-based payments provide enhanced support for primary care practices, reducing overlap and redundancy. Given these considerations, along with the lack of diagnosis-specific billing requirements for G2211 and alignment issues with the Department's shift away from fee-for-service, the Department concludes that the costs and duplication of services outweigh the potential benefits.

Please refer to page 87 of Speech Therapy section for a detailed explanation of the GT modifier.

Physician Services - Radiology

Service Description

Radiology services primarily consist of imaging services. These services include but are not limited to angiograms, computed tomography (CT scans), electrocardiograms (ECG), magnetic resonance imaging (MRI scans), mammograms, positron emission tomography (PET scans), radiation treatment, ultrasounds, and X-rays.

A summary of the statistics for the radiology service subcategory is provided below:

Physician Services - Radiology Statistics	
Total Adjusted Expenditures SFY 2023-24	\$66,926,268
Total Members Utilizing Services in SFY 2023-24	355,125
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-9.44%
Total Active Providers SFY 2023-24	7,896
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-3.26%

Table 118. Physician Services - Radiology total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The radiology service grouping has 1,791 procedure code/modifier combinations. The rates for 1,626 of them (90.79%) were compared to Medicare, while the rates for 135 of them (7.54%) were compared to rates from other states. Among these 1,761 codes, 765 of them (43.44%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, 30 combinations (1.68%) were excluded due to no valid benchmark rates found. Individual rate ratios for radiology were 3.58% - 667.47%.

On average, Colorado Medicaid payments for radiology are estimated at 98.29% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Radiology Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$66,926,268	\$68,091,796	98.29%

Table 119. Comparison of Colorado Medicaid Physician Services - Radiology service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,165,528 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the radiology panel size visual (Appendix B, Figure 176), the average number of utilizers per provider in urban and rural areas was stable. The penetration rate visual (Appendix B, Figure 178) shows that utilization per 1000 members was moderately high statewide. The special providers visual (Appendix B, Figure 179) shows that the percent of active providers that served only one Medicaid member remained stable. Finally, the drive time analysis (Appendix B, Figure 180) shows that drive times were relatively low statewide. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - radiology.

Physician Services - Radiology Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	71045+26	X-RAY EXAM CHEST 1 VIEW	134.4%	134,044	10.19%
2	74177+26	CT ABD & PELV W/CONTRAST	90.8%	58,194	4.43%
3	70450+26	CT HEAD/BRAIN W/O DYE	106.5%	49,881	3.79%
4	71046+26	X-RAY EXAM CHEST 2 VIEWS	173.2%	48,508	3.69%
5	74018+26	X-RAY EXAM ABDOMEN 1 VIEW	140.3%	26,390	2.01%
6	76705+26	ECHO EXAM OF ABDOMEN	99.6%	25,553	1.94%
7	73630+26	X-RAY EXAM OF FOOT	85.2%	23,247	1.77%
8	73610+26	X-RAY EXAM OF ANKLE	85.2%	20,244	1.54%
9	73130+26	X-RAY EXAM OF HAND	85.2%	19,542	1.49%
10	72125+26	CT NECK SPINE W/O DYE	102.4%	19,493	1.48%

Table 120. Physician Services - Radiology top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. Two outlier charts were created to highlight codes with benchmark ratio above 140% and below 60%. To protect PHI, 11 low-utilization outliers were excluded from the high-ratio chart, and 15 from the low-ratio chart.

As shown in the high-ratio bubble chart below (Figure 30), there are 10 outliers with benchmark ratio above 140% grouped into 2 clusters:

- Cluster 1 includes eight outliers, with benchmark ratio ranging between 148.12% - 306.67%. Their repriced amounts range between \$1,131 (0.002% of the total) to \$225,392 (0.34% of the total), and their utilization ranges from 38 (0.003% of the total) - 3,536 (0.27% of the total) allowed units. Overall, this cluster contains outliers with low utilization and low repriced amount outliers.
- Cluster 2 includes the professional components of two procedure codes, 74018 and 71046. Their benchmark ratios are 140.29%, and 173.18%, the repriced amounts are \$314,253 (0.47% of the total) and \$848,296 (1.27% of the total), and the utilization amounts are 26,390 (2.01% of the total) and 48,508 (3.69% of the total) allowed units, respectively. Overall, this cluster contains outliers with the highest utilization and repriced amount among all outliers in this service group.

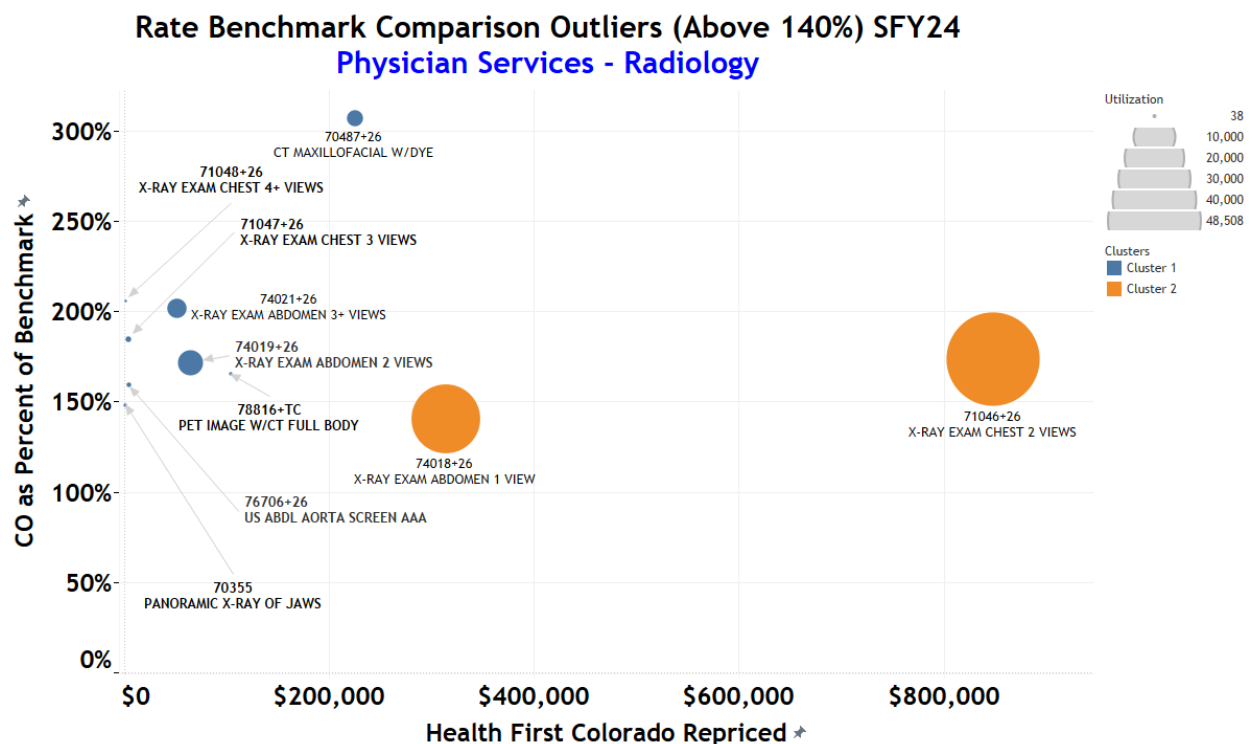


Figure 30. Bubble Chart indicating the outliers over 140% found for Physician Service - Radiology

As shown in the low-ratio bubble chart below (Figure 31), there are 8 outliers with benchmark ratio 60% grouped into 2 clusters:

- Cluster 1 includes three outliers, 19083, 76882, and 10005 with benchmark ratio ranging between 44.51% - 59.75%. Their repriced amounts range between \$54,615 (0.08% of the total) to \$267,596 (0.40% of the total), and their utilization ranges from 1,050 (0.08% of the total) - 1,548 (0.12% of the total) allowed units.
- Cluster 2 includes five outliers, professional components of code 76882, code 19084, 19082, 19081, and 19085, with benchmark ratio ranging between 24.97% and 53.18%. Their repriced amounts range between \$274 (0.0004% of the total) to \$77,079 (0.12% of the total), and their utilization ranges from 34 (0.003% of the total) - 381 (0.03% of the total) allowed units.

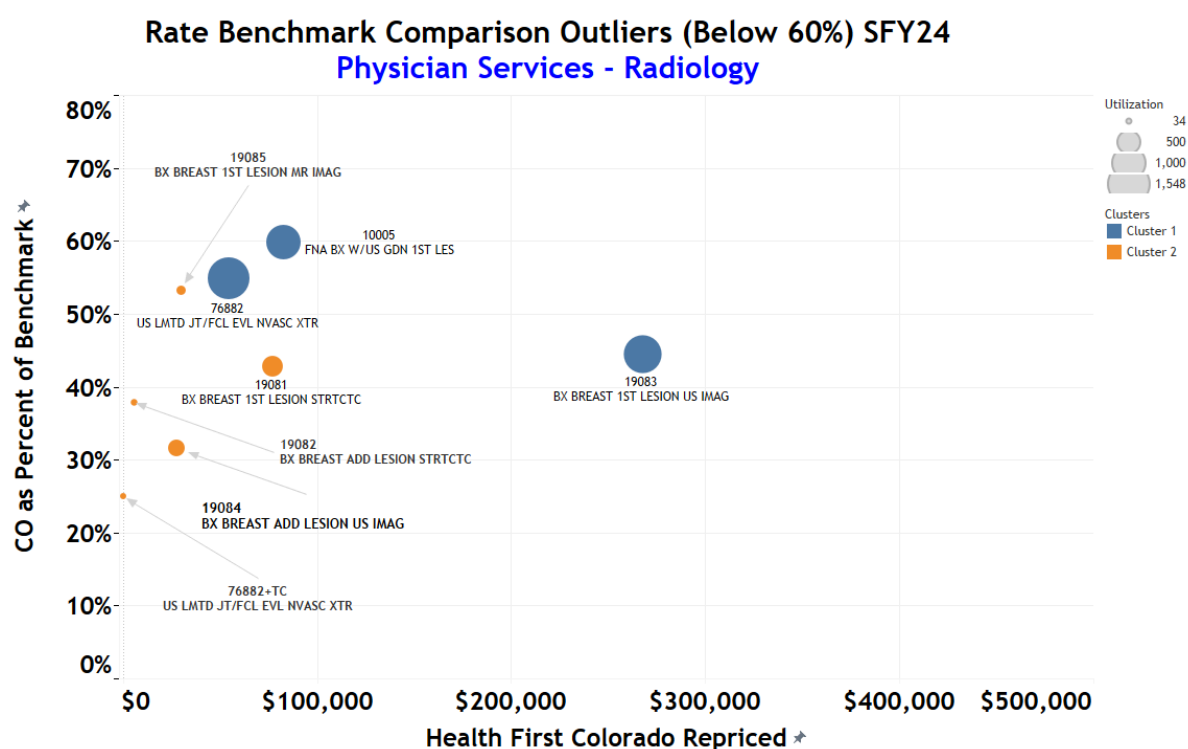


Figure 31. Bubble Chart indicating the outliers below 60% found for Physician Service - Radiology

MPRRAC Recommendations

- For codes with benchmark ratios, MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark. This recommendation excludes all chest X-ray codes (71045, 71046, 71047, and 71048), abdominal X-ray codes (74018, 74019, 74021, and 74022), and ultrasound abdominal aortic aneurysm screening code (76706).

- For colon cancer screening codes with benchmark ratios (74261, 74262, 74263, 74270, and 74280), MPRRAC recommends increasing rates to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$211,008 total funds, including \$57,859 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark. HCPF also recommends decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark. This recommendation excludes all chest X-ray codes (71045, 71046, 71047, and 71048), abdominal X-ray codes (74018, 74019, 74021, and 74022), and ultrasound abdominal aortic aneurysm screening code (76706).
- For colon cancer screening codes with benchmark ratios (74261, 74262, 74263, 74270, and 74280), HCPF recommends increasing rates to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be \$211,005 total funds, including \$57,858 General Fund.

Physician Services - Respiratory

Service Description

Respiratory services include diagnostic evaluation and procedures of the nose, trachea, bronchi, lungs, and pleura (a set of membranes which cover the lungs). This service category also includes the management of chronic respiratory conditions such as COPD (Chronic Obstructive Pulmonary Disease) and asthma.

A summary of the statistics for the Respiratory service subcategory is provided below:

Physician Services - Respiratory Statistics	
Total Adjusted Expenditures SFY 2023-24	\$1,145,246
Total Members Utilizing Services in SFY 2023-24	43,165
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-12.76
Total Active Providers SFY 2023-24	2,298
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-2.05%

Table 121. Physician Services - Respiratory total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The Respiratory service grouping has 91 procedure code/modifier combinations. The rates for 83 of them (91.21%) were compared to Medicare, while the rates for five codes (5.49%) were compared to rates from other states. When comparing procedure code/modifier combinations across a selection of states, some states may lack rates for certain codes due to different Medicaid models, services not being covered, or variations in state-specific service definition. This leads to inconsistencies in the number of benchmark states available for different codes:

Physician Services - Respiratory Benchmark States	
Procedure Code	Benchmark State ³³
94150	Arizona, Nevada, Oklahoma, and Utah
94642	Arizona, Nebraska, Nevada, Oklahoma, Oregon, and Utah
94150+26, and 94150+TC	Arizona, Nebraska, Nevada, Oregon, and Utah
94772	Nebraska, Oregon, and Utah

Table 122. Physician Services - Respiratory Benchmark States (SFY 2023-24).

Among these 88 reviewed codes, 41 of them (46.59%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, 3 combinations (3.30%) are excluded due to no valid benchmark rates found. Individual rate ratios for Respiratory were 27.26% - 391.89%.

³³ Please refer to the “Benchmark Rationale” provided under “Physician Services” on page 108 for benchmark rationale for all physician services.

On average, Colorado Medicaid payments for Respiratory are estimated at 103.00% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Respiratory Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$1,145,246	\$1,111,929	103.00%

Table 123. Comparison of Colorado Medicaid Physician Services - Respiratory service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$33,317 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the respiratory panel size visual (Appendix B, Figure 181), the average number of utilizers per provider in urban areas decreased from SFY 2021-22 to SFY 2023-24. The special providers visual (Appendix B, Figure 184) shows that the percent of active providers that served only one Medicaid member remained stable. Finally, Colorado Medicaid had higher per utilizer per year utilization than other payers (Appendix B, Figure 185). These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - Respiratory.

Physician Services - Respiratory Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization

1	94760	MEASURE BLOOD OXYGEN LEVEL	74.1%	42,294	48.61%
2	94640	AIRWAY INHALATION TREATMENT	172.3%	7,932	9.12%
3	94010	BREATHING CAPACITY TEST	123.1%	7,473	8.59%
4	94375+26	RESPIRATORY FLOW VOLUME LOOP	107.9%	3,996	4.59%
5	94060+26	EVALUATION OF WHEEZING	125.3%	3,845	4.42%
6	94060	EVALUATION OF WHEEZING	109.4%	2,930	3.37%
7	94729+26	CO/MEMBANE DIFFUSE CAPACITY	83.4%	2,714	3.12%
8	94375	RESPIRATORY FLOW VOLUME LOOP	96.1%	2,668	3.07%
9	94726+26	PULM FUNCT TST PLETHYSMOGRAP	93.5%	2,303	2.65%
10	94762	MEASURE BLOOD OXYGEN LEVEL	116.4%	1,867	2.15%

Table 124. Physician Services - Respiratory top 10 procedure codes ranked by utilization

Year-over-Year Reimbursement Rate Trend Analysis

The respiratory subcategory has an overall benchmark ratio of 103.00%, indicating that Colorado Medicaid reimbursement exceeds Medicare benchmarks on average. To better understand this high benchmark ratio, HCPF conducted a year-over-year reimbursement rate percentage changes analysis across all 83 procedure code and modifier combinations using Medicare for benchmarking. 31 of these 83 codes have a benchmark ratio above 100%, with 21 of them showing utilization in SFY 2023-24.

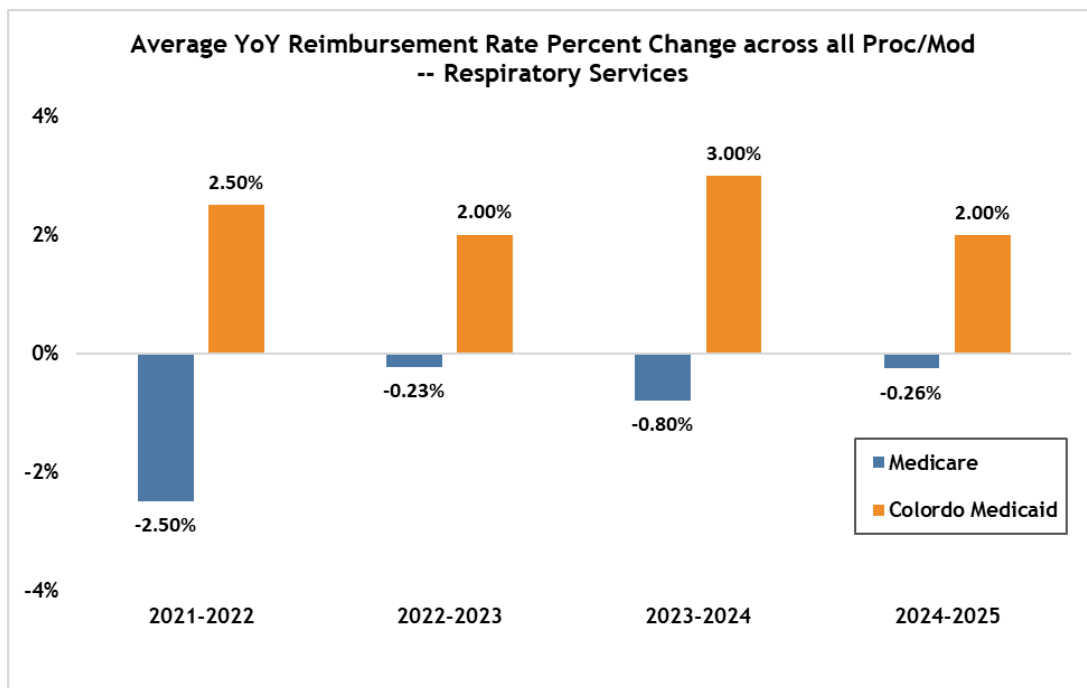


Figure 32. Bar chart indicating the average year-over-year Physician Services - Respiratory reimbursement rate percentage changes for Medicare and Colorado Medicaid

As shown in Figure 32, over the 4-year time period from 2021 - 2025³⁴, Medicare rates for all these 83 codes declined by an average of 3.84%, while Colorado Medicaid rates increased by an average of 9.84%. The divergence in rate trends has resulted in an elevated overall benchmark ratio, calculated as Colorado's repriced amount divided by Medicare's repriced amount.

Among the 83 codes, the following two have the highest benchmark ratio to Medicare:

- 94640: AIRWAY INHALATION TREATMENT, Medicare rate dropped 45.56% from \$14.88 to \$8.1, current benchmark ratio is 172.25%
- 94200 + 26: LUNG FUNCTION TEST (MBC/MVV), professional component, Medicare rate dropped 32.81% from \$3.84 to \$2.58, current benchmark ratio is 179.07%

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, six outliers with low utilization were excluded from this service category.

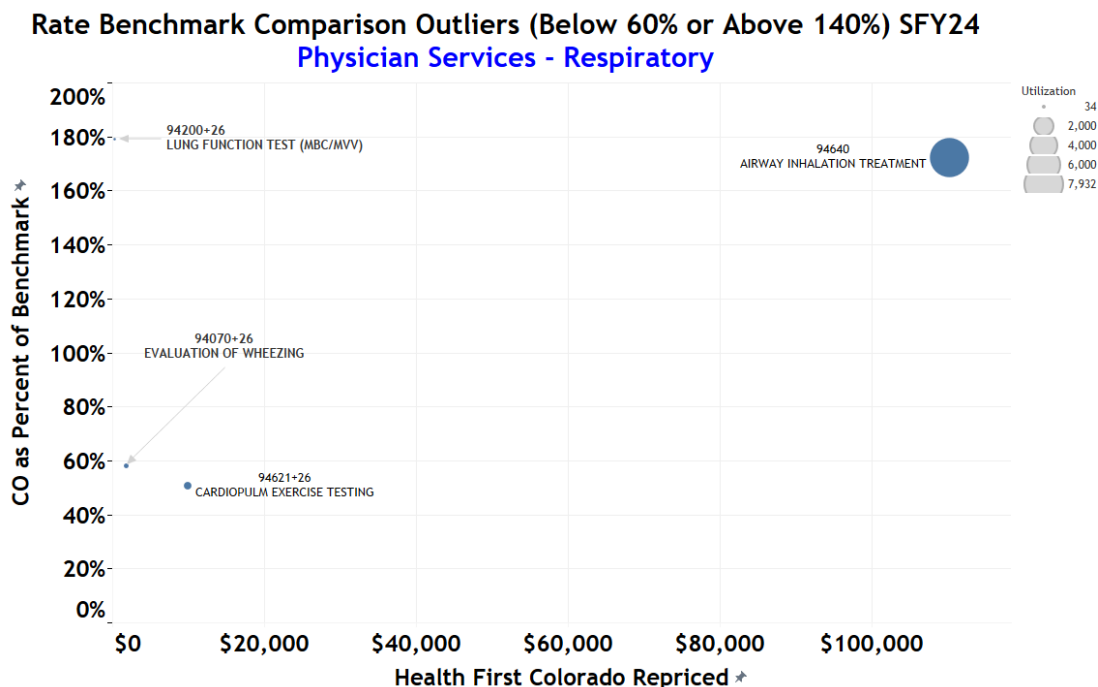


Figure 33. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Respiratory

³⁴ “Over the 4-year time period from 2021-2025” refers to the span during which annual rate changes were analyzed. The rate change calculations are conducted between each pair of consecutive years (i.e., 2021-2022, 2022-2023, etc.) across this period. (1) Medicare rates are assessed on a calendar year basis (January-December); (2) Medicaid rates are assessed on a fiscal year basis (July-June).

The bubble chart above (Figure 33) indicates that there are four outliers displayed for respiratory:

- Two outliers, 94621, and 94070, have benchmark ratios 50.76% and 57.88%. Their repriced amounts are \$9,936 (0.87% of the total) and \$1,748 (0.16% of the total), and their utilization amounts are 299 (0.34% of the total) and 116 (0.13% of the total) allowed units, respectively.
- Two outliers, 94640, and 94200, have benchmark ratios 172.25% and 179.07%. Their repriced amounts are \$110,247 (9.68% of the total) and \$157 (0.01% of the total), and their utilization amounts are 7,932 (9.12% of the total) and 34 (0.04% of the total) allowed units, respectively.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be -\$30,130 total funds, including -\$8,262 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark, decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark, and keeping the rates for all other codes the same.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of the HCPF's recommendation is estimated to be -\$30,130 total funds, including -\$8,262 General Fund.

Physician Services - Sleep Study

Service Description

Sleep studies refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with six or more hours of recording with physician review, interpretation and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). This service is typically provided by hospitals, clinics, independent laboratories, or Independent Diagnostic Testing Facilities (IDTF).

A summary of the statistics for the sleep study service subcategory is provided below:

Physician Services - Sleep Study Statistics	
Total Adjusted Expenditures SFY 2023-24	\$3,540,026
Total Members Utilizing Services in SFY 2023-24	12,522
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-3.16%
Total Active Providers SFY 2023-24	198
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	10.61%

Table 125. Physician Services - Sleep Study total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The sleep study service grouping has 42 procedure code/modifier combinations. The rates for 33 of them (78.57%) were compared to Medicare. The remaining nine code combinations (21.43%) were compared to rates from Nevada and Oregon, as comparable data were not available from the other four states—Arizona, Nebraska, Oklahoma, and Utah. Among these 42 codes, 15 of them (35.71%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for sleep study were 30.53% - 238.22%.

On average, Colorado Medicaid payments for sleep study are estimated at 123.65% of the benchmark indicating that Colorado Medicaid reimbursement exceeds the Medicare benchmarks on average. The 2024 review of this subcategory³⁵ included an analysis of trends from 2020 to 2024, which showed a 5.84% decrease in Medicare reimbursement rates, contrasted by a 6.61% increase in Colorado Medicaid rates over the same period. This divergence in rate trajectories has contributed to a higher overall benchmark ratio, calculated as Colorado's repriced amount divided by Medicare's repriced amount. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

³⁵ For additional details, see the *2024 Medicaid Provider Rate Review Analysis and Recommendation Report*, available at: <https://hcpf.colorado.gov/sites/hcpf/files/2024%20Medicaid%20Provider%20Rate%20Review%20Analysis%20and%20Recommendation%20Report.pdf>.

Sleep Study Repriced Benchmark Comparison		
Colorado Repriced	Medicare/2 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$3,540,026	\$2,862,835	123.65%

Table 126. Comparison of Colorado Medicaid Physician Services - Sleep Study service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be -\$677,191 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the sleep study panel size visual (Appendix B, Figure 186), the average number of utilizers per provider in urban and rural areas was overall stable. The penetration rate visual (Appendix B, Figure 188) shows that utilization per 1000 members was moderate in the Eastern half of the state. The percentage of active providers that served Medicaid members was 13% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 189) shows that the percent of active providers that served only one Medicaid member increased. The drive time analysis (Appendix B, Figure 190) shows that drive times were relatively high (over an hour) in some parts of the state. Finally, Colorado Medicaid had higher per utilizer per year utilization than other payers (Appendix B, Figure 191). These findings indicate that access to care could be impacted as a result of relatively low provider participation and longer distances to providers.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - sleep study.

Physician Services - Sleep Study Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization

1	91200	POLYSOM 6/> YRS 4/> PARAM	117.4%	2,922	18.69%
2	91200+26	SLEEP STUDY UNATT&RESP EFFT	221.5%	2,468	15.78%
3	91065+26	SLEEP STUDY UNATT&RESP EFFT	198.0%	2,228	14.25%
4	91010+26	POLYSOM 6/>YRS CPAP 4/> PARM	116.9%	1,977	12.64%
5	91110	SLP STDY UNATTENDED	137.8%	1,415	9.05%
6	91035+26	SLP STDY UNATTENDED	133.8%	959	6.13%
7	91110+26	POLYSOM 6/> YRS 4/> PARAM	109.4%	909	5.81%
8	91122+26	POLYSOM 6/>YRS CPAP 4/> PARM	107.9%	795	5.08%
9	91037+26	POLYSOM <6 YRS 4/> PARAMTRS	94.2%	557	3.56%
10	91010	POLYSOM 6/> YRS 4/> PARAM	107.6%	342	2.19%

Table 127. Physician Services - Sleep Study top 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, seven outliers with low utilization were excluded from this service category, five with benchmark ratio below 60% and two above 140%.

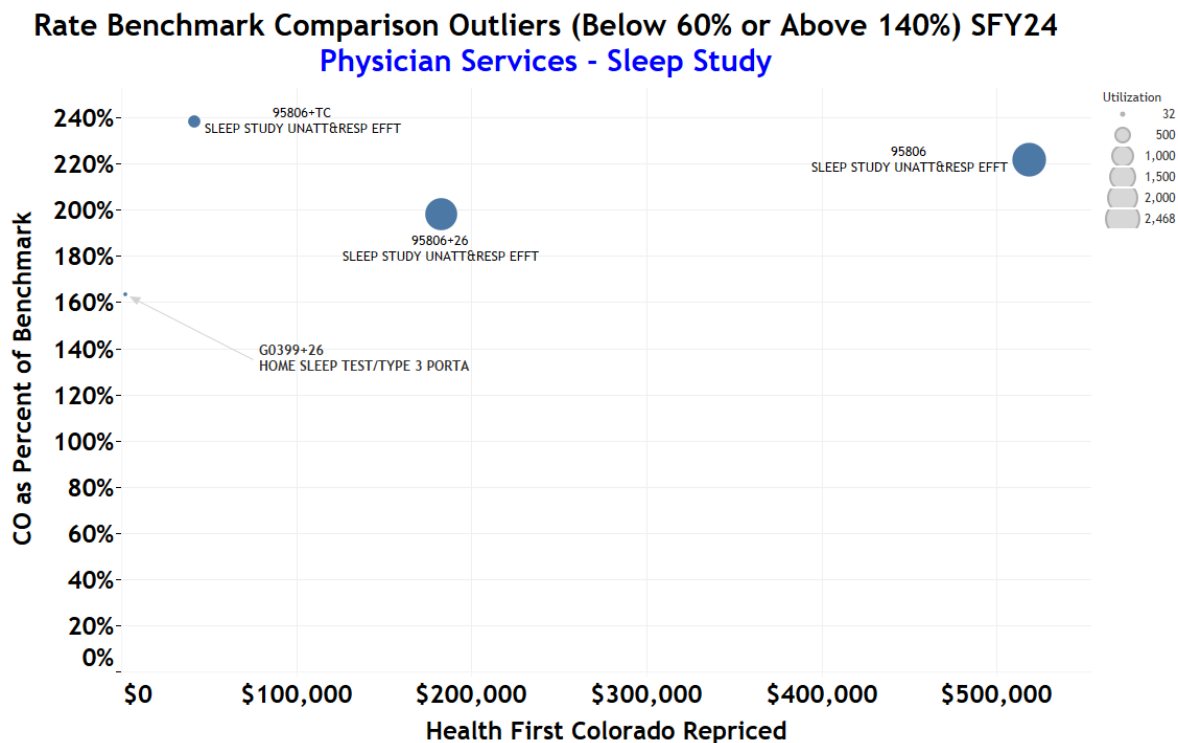


Figure 34. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Sleep Study

The bubble chart above (Figure 34) indicates that there are four outliers, G0399, 95806, 95806+26, and 95806+TC displayed for sleep study, with benchmark ratios ranging from 163.37% to 238.22%. Their repriced amounts range from \$2,227 (0.06% of the total) and \$518,612 (14.65% of the total), and their utilization amounts are between 32 (0.20% of the total) and 2,468 (15.78% of the total) allowed units.

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the unattended sleep study codes with rates above 140% of benchmark to 140% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be -\$259,414 total funds, including -\$71,131 General Fund.

HCPF Recommendations

- For attended sleep study codes (95800, 95806, G0399, G0398), HCPF recommends reducing the rates above 140% of the benchmark to 140%. While rate reductions are typically brought down to 100% of the benchmark, a higher threshold was applied in this case to account for the comparatively lower reimbursement rates of these codes than in other settings. This approach balances cost containment with maintaining reasonable rate differentials across related services.
- For other codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and keeping the rates for all codes above 80% of the benchmark the same.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$259,414 total funds, including -\$71,131 General Fund.

Physician Services - Vaccines Immunizations

Service Description

Vaccines and Immunizations services promote and facilitate the prevention of preventable diseases. All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are covered for all members. Additionally members under the age of 19 receive all vaccines included in the Vaccines for Children (VFC) Program via VFC providers who are also enrolled Medicaid providers.

A summary of the statistics for the vaccines and immunizations service subcategory is provided below:

Physician Services - Vaccines and Immunizations Statistics	
Total Adjusted Expenditures SFY 2023-24	\$23,640,025
Total Members Utilizing Services in SFY 2023-24	213,285
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-8.32%
Total Active Providers SFY 2023-24	7,678
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	2.58%

Table 128. Physician Services - Vaccines and Immunizations total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The vaccines and immunizations service grouping has 87 procedure code/modifier combinations. The rates for 32 of them (36.78%) were compared to Medicare, while the rates for 38 codes (43.68%) were compared to rates from other states. Among these 70 code combinations, nine of them (12.86%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Moreover, 17 combinations (19.54%) are excluded due to no valid benchmark rates found. Individual rate ratios for radiology were 43.94% - 249.96%.

On average, Colorado Medicaid payments for vaccines and immunizations are estimated at 95.12% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Vaccines and Immunizations Repriced Benchmark Comparison		
Colorado Repriced	Medicare/6 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$23,640,025	\$24,852,249	95.12%

Table 129. Comparison of Colorado Medicaid Physician Services - Vaccines and Immunizations service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$1,212,224 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the vaccines and immunizations panel size visual (Appendix B, Figure 192), the average number of utilizers per provider in urban and rural areas had a similar pattern and trend. The penetration rate visual (Appendix B, Figure 194) shows that utilization per 1000 members was moderate to high statewide. The percentage of active providers that served Medicaid members was 56% in SFY 2023-24. Moreover, the special providers visual (Appendix B, Figure 195) shows that the percent of active providers that served only one Medicaid member remained stable. These findings indicate that access to care is stable.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - vaccines and immunizations.

Physician Services - Vaccines and Immunizations Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	90460	IM ADMIN 1ST/ONLY COMPONENT	91.9%	237,718	34.71%
2	90471	IMMUNIZATION ADMIN	101.8%	129,883	18.97%
3	96372	THER/PROPH/DIAG INJ SC/IM	103.9%	83,753	12.23%
4	90472	IMMUNIZATION ADMIN EACH ADD	83.6%	50,345	7.35%
5	90686	IIV4 VACC NO PRSV 0.5 ML IM	109.2%	38,186	5.58%
6	90480	ADMN SARSCOV2 VACC 1 DOSE	68.9%	37,682	5.50%
7	90715	TDAP VACCINE 7 YRS/> IM	124.1%	19,262	2.81%
8	91320	CORONAVIRUS VACCINE 21	85.7%	13,928	2.03%
9	91322	CORONAVIRUS VACCINE 23	92.1%	13,570	1.98%
10	90750	HZV VACC RECOMBINANT IM	101.9%	8,372	1.22%

Table 130. Physician Services - Vaccines and Immunizations 10 procedure codes ranked by utilization

Outlier Analysis for Utilized Codes

The MPRRAC requested to view data on the outliers for each service category for codes with utilization in SFY 2023-24. Outliers are defined as Colorado Medicaid reimbursement rates that are under 60% or above 140% of the benchmark rate. To protect PHI, two low-utilization outliers with benchmark ratio above 140% were excluded from the chart.

The bubble chart below (Figure 35) indicates that there are two outliers, 90688 and 90384 displayed for vaccines and immunization service grouping. Their benchmark ratios are 56.84% and 180.40%, their repriced amounts are \$46,031 (0.19% of the total) and \$13,847 (0.06% of the total), and their utilization amounts are 32,205 (0.32% of the total) and 105 (0.02% of the total) allowed units, respectively.

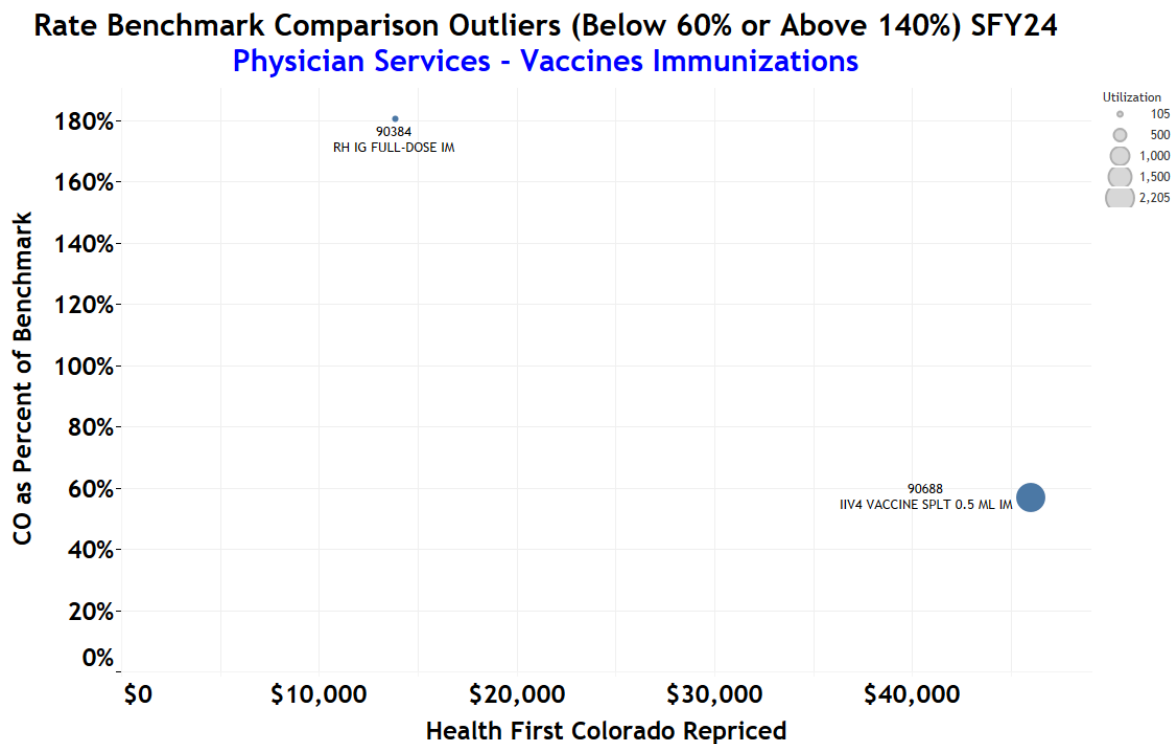


Figure 35. Bubble Chart indicating the outliers under 60% and over 140% found for Physician Service - Vaccines and Immunizations

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark.
- For codes 90460, 90471, and 90473, the MPRRAC recommends increasing the rates to the regional-allowed maximum rate (\$21.68).

- For codes with valid Colorado rates but without benchmark ratios, the MPRRAC recommends increasing the rates by 3%.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$342,172 total funds, including \$93,823 General Fund.

HCPF Recommendations

- HCPF recommends no changes to codes with rates set using CDC values.
- These administration codes are currently at 95% benchmark ratio; therefore, HCPF recommends maintaining current rates to align with existing budget constraints.
- For other codes with benchmark ratios, HCPF recommends increasing the rates for all codes that are under 80% of the benchmark ratio to 80% of the benchmark and decreasing the rates for all codes that are above 100% of the benchmark to 100% of the benchmark.
- For codes with valid Colorado rate but without benchmark ratios, HCPF recommends no change due to budget constraints.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be -\$169,896 total funds, including -\$46,585 General Fund.

Physician Services - Vascular

Service Description

Vascular services involve testing and treatment related to the functioning of arteries and veins. The treatment for conditions such as peripheral artery disease (PAD), deep vein thrombosis (DVT), varicose veins, and aneurysms fall into this category.

A summary of the statistics for the Vascular service subcategory is provided below:

Physician Services - Vascular Statistics	
Total Adjusted Expenditures SFY 2023-24	\$3,558,628
Total Members Utilizing Services in SFY 2023-24	35,429
SFY 2023-24 Over SFY 2022-23 Change in Members Utilizing Services	-7.65%
Total Active Providers SFY 2023-24	1,103
SFY 2023-24 Over SFY 2022-23 Change in Active Providers	-1.52%

Table 131. Physician Services - Vascular total expenditure and utilization data (SFY 2023-24).

Rate Comparison Analysis

The Vascular service grouping has 75 procedure code/modifier combinations. The rates for 72 of them (96%) were compared to Medicare, while the rates for three codes (4%) were compared to rates from five other states (Arizona, Nebraska, Nevada, Oklahoma, and Utah) as comparable data were not available from Oregon.

Among these 75 combinations, 13 of them (17.33%) did not have valid utilization during SFY 2023-24. A rate-only comparison was performed for these codes. Individual rate ratios for Vascular were 75.80% - 205.54%.

On average, Colorado Medicaid payments for Vascular are estimated at 99.61% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Vascular Repriced Benchmark Comparison		
Colorado Repriced	Medicare/5 Benchmark States Repriced	Overall Repriced Benchmark Ratio
\$3,558,628	\$3,572,572	99.61%

Table 132. Comparison of Colorado Medicaid Physician Services - Vascular service payments to those of other payers, expressed as a percentage (SFY 2023-24).

The estimated fiscal impact to Colorado Medicaid would be \$13,944 total funds if Colorado had reimbursed at 100% of the benchmark in SFY 2023-24.

Access to Care Analysis

As seen in the vascular panel size visual (Appendix B, Figure 198), the average number of utilizers per provider in urban and rural areas was overall stable. The penetration rate visual (Appendix B, Figure 200) shows that utilization per 1000 members was moderate in much of the state. The special providers visual (Appendix B, Figure 201) shows that the percent of active providers that served only one Medicaid member remained stable. The drive time analysis (Appendix B, Figure 202) shows that parts of Eastern and Western Colorado had relatively high (over an hour) drive times. These findings indicate that access to care may be impacted by longer driving distances to providers.

See Appendix B for the full access to care analysis.

Stakeholder Engagement

See Appendix I for Stakeholder Feedback.

Additional Research

Utilization Analysis

The MPRRAC requested to view data on the top 10 procedure codes by utilization for each service category. The table below ranks the dialysis rate types with the highest utilization for physician services - Vascular.

Physician Services - Vascular Top 10 Procedure Codes by Utilization					
Rank	Code + Modifier	Service Description	Benchmark Ratio	Utilization	% of Total Utilization
1	93971+26	EXTREMITY STUDY	86.2%	12,759	23.90%
2	93975+26	VASCULAR STUDY	107.5%	10,356	19.40%
3	93970+26	EXTREMITY STUDY	108.5%	6,086	11.40%
4	93976+26	VASCULAR STUDY	106.5%	5,678	10.64%
5	93971	EXTREMITY STUDY	94.0%	4,985	9.34%
6	93970	EXTREMITY STUDY	93.6%	3,214	6.02%
7	93976	VASCULAR STUDY	107.1%	1,411	2.64%
8	93975	VASCULAR STUDY	108.9%	971	1.82%
9	93923	UPR/LXTR ART STDY 3+ LVLS	100.7%	799	1.50%
10	93880+26	EXTRACRANIAL BILAT STUDY	85.7%	733	1.37%

Table 133. Physician Services - Vascular top 10 procedure codes ranked by utilization

MPRRAC Recommendations

- For codes with benchmark ratios, the MPRRAC recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendation is estimated to be \$279 total funds, including \$76 General Fund.

HCPF Recommendations

- For codes with benchmark ratios, HCPF recommends increasing rates under 80% of the benchmark to 80% of the benchmark, and decreasing the rates above 140% of benchmark and compared to Medicare to 100% of the benchmark.
- The anticipated fiscal impact of HCPF's recommendation is estimated to be \$279 total funds, including \$76 General Fund.

Appendices

[Appendix A - Research Methodology](#)

Provides explanations of methodologies and data used in this report.

[Appendix A1 - Base Data Summary](#)

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

[Appendix A2 - Benchmark Ratios](#)

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

[Appendix A3 - Duplicate Code List](#)

Contains a list of duplicate code and modifier combinations that appeared in billing manuals for multiple services. It identifies the codes, modifiers, their descriptions, the services they are listed under, and the service under which each combination was reviewed to maintain consistency in the rate payment methodology.

[Appendix A4 - Excluded Codes](#)

Contains the codes and relevant modifier combinations, by service category, that were excluded from the rate comparison analysis and the reason for their exclusion.

[Appendix B - Access to Care Metrics](#)

Contains the access to care metrics across each applicable service category, with their associated descriptions, data visualizations, and explanations of results, which include: panel size, penetration rate, special provider, telemedicine analysis, drive times, provider participation, and per utilizer per year/month (PUPY/PUPM) expenditures and utilization.

[Appendix C - Rate Change Track Document](#)

Contains a detailed overview of all the codes for the services under review. Where applicable, this includes the original Colorado Medicaid rates used for repricing (July 2024 fee schedule), proposed rates based on MPRRAC's recommendations, proposed rates based on HCPF's recommendations, and JBC approved rates (to be added when available after April 2026).

[Appendix D - Benchmark State Selection Rationale](#)

Contains the benchmark state selection rationale for each service category reviewed in 2025, outlining the basis for which states were chosen for comparison in the rate review process when no Medicare rates were applicable.

[Appendix D.1 - DIDD Benchmark State Rate Crosswork](#)

Provides detailed benchmark rationale for Dental IDD service against Colorado Medicaid Dental State Plan, American Dental Association (ADA), and other states. It also contains the clarification on the

benchmarking process, and how the benchmark ratio was calculated for each Current Dental Terminology (CDT) code.

[Appendix D.2 - Specialty Care Skin Substitute Benchmark State Rate Crosswork](#)

Provides the detailed benchmark rationale for Specialty Care Services compared with other states. It also clarifies the process used to map benchmark state rates into Colorado Medicaid Specialty Care Skin Substitute groups.

[Appendix D.3 - Early Intervention TCM Benchmark State Rate Crosswork](#)

Provides clarification on the process for mapping benchmark state rates for each HCPCS code reviewed under the Early Intervention TCM service group and explains how the benchmark ratio was calculated.

[Appendix D.4 - TCM - Case Management Benchmark State Rate Crosswork](#)

Provides clarification on the process for mapping benchmark state rates for each HCPCS code reviewed under the TCM-Case Management service group and explains how the benchmark ratio was calculated.

[Appendix D.5 - TCM - Transition Coordination Benchmark State Rate Crosswork](#)

Provides clarification on the process for mapping benchmark state rates for each HCPCS code reviewed under the TCM-Transition Coordination service group and explains how the benchmark ratio was calculated.

[Appendix E - CBIZ Optumas Justification of Dialysis Medicare Repriced Methodology](#)

Describes the methodology used by CBIZ Optumas to reprice Colorado Medicaid dialysis payments against Medicare benchmarks. It outlines the adjustments applied for labor costs, patient characteristics, and service settings, as well as the limitations due to unavailable data.

[Appendix F1 - State Plan Version 08.07.25](#)

This is the State Plan Amendment outlining the \$5 GT modifier add-on for telemedicine codes and the telehealth transmission fee. This appendix provides the policy basis for these payments and highlights that any removal would require stakeholder engagement and a formal SPA amendment.

[Appendix F2 - Recommendation G2211 Services eClearance Final](#)

Provides the Department's detailed analysis and recommendation on HCPCS code G2211, including fiscal impact estimates, alignment with existing value-based payment models, and the rationale for not adopting coverage for this code.

[Appendix G - 2025 Tariff Survey Analysis Result](#)

Provides more detailed information on the survey sent to providers for completion regarding federal tariffs.

[Appendix H - Cost of Living Index \(Q3 2024\)](#)

Provides the 2024 third-quarter average cost of living numbers downloaded from the Missouri Economic Research and Information Center. The index values were used to normalize benchmark state Medicaid rates for comparison with Colorado Medicaid Rates.

[Appendix I - Stakeholder Feedback](#)

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

[Appendix J - Glossary and County Reference Map](#)

Provides explanations for common terms used throughout the 2025 Medicaid Provider Rate Review Analysis Report, as well as a reference map of counties in Colorado by classification.