COLORADO
Department of Health Care Policy & Financing

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

November 5, 2020

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

Dear Representative Esgar:

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

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Pediatric Personal Care (PPC), Home Health services, Private Duty Nursing (PDN), Pediatric Behavioral Therapy (PBT), Speech Therapy, Physical and Occupational Therapy (PT/OT), Prosthetics, Orthotics and Supplies (POS), and Vision services, under review in year five of the Rate Review Process.

If you require further information or have additional questions, please contact the Department's Legislative Analyst, Jill Mullen, at Jill.Mullen@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2020 Medicaid Provider Rate Review Recommendation Report

CC: Senator Dominick Moreno, Vice-chair, Joint Budget Committee
Representative Julie McCluskie, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
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Legislative Council Library
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John Bartholomew, Finance Office Director, HCPF
Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Anne Saumur, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF

COLORADO
Department of Health Care Policy & Financing

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

November 5, 2020

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

Dear Mr. Dienst:

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

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Pediatric Personal Care (PPC), Home Health services, Private Duty Nursing (PDN), Pediatric Behavioral Therapy (PBT), Speech Therapy, Physical and Occupational Therapy (PT/OT), Prosthetics, Orthotics and Supplies (POS), and Vision services, under review in year five of the Rate Review Process.

If you require further information or have additional questions, please contact the Department's Rate Review Stakeholder Relations Specialist, Eloiss Hulsbrink, at Eloiss.Hulsbrink@state.co.us or (303) 866-6214.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2020 Medicaid Provider Rate Review Recommendations Report

Cc: Dixie Melton, Vice-chair, Medicaid Provider Rate Review Advisory Committee
David Friedenson, Medicaid Provider Rate Review Advisory Committee
Steven Hehnen, Medicaid Provider Rate Review Advisory Committee
Rob Hernandez, Medicaid Provider Rate Review Advisory Committee
Vennita Jenkins, Medicaid Provider Rate Review Advisory Committee
Kimberly Kretsch, Medicaid Provider Rate Review Advisory Committee
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Rachel Reiter, External Relations Division Director, HCPF

2020 Medicaid Provider Rate Review Recommendation Report

November 1, 2020

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

COLORADO
Department of Health Care Policy & Financing

Contents

Executive Summary **4**

Introduction **7**

Report Purpose 7

Payment Philosophy 8

Format of Report 9

Pediatric Personal Care **10**

Summary of Findings 10

Key Considerations 10

Stakeholder Feedback 10

Additional Considerations 10

Department Recommendations 10

Home Health Services **11**

Summary of Findings 11

Key Considerations 11

Stakeholder Feedback 11

Additional Considerations 11

Department Recommendations 12

Private Duty Nursing (PDN) **14**

Summary of Findings 14

Key Considerations 14

Stakeholder Feedback 14

Additional Considerations 14

Department Recommendations 14

Pediatric Behavioral Therapy (PBT) **15**

Summary of Findings 15

Key Considerations 15

Stakeholder Feedback 15

Additional Considerations 15

Department Recommendations 15

Speech Therapy **16**

Summary of Findings 16

Key Considerations 16

Stakeholder Feedback 16

Additional Considerations 16

COLORADO
Department of Health Care Policy & Financing

Department Recommendations 17
Physical and Occupational Therapy (PT/OT) 18
Summary of Findings 18
Key Considerations 18
Stakeholder Feedback 18
Additional Considerations 18
Department Recommendations 18
Prosthetics, Orthotics, and Supplies (POS) 19
Summary of Findings 19
Key Considerations 19
Stakeholder Feedback 19
Additional Considerations 19
Department Recommendations 19
Vision 20
Summary of Findings 20
Key Considerations 20
Stakeholder Feedback 20
Additional Considerations 20
Department Recommendations 20

COLORADO
Department of Health Care Policy & Financing

Executive Summary

This report contains the Colorado Department of Health Care Policy & Financing's (the Department) review of rates paid to specific provider types under the Colorado Medical Assistance Act. Services under review this Year Five of the five-year review cycle - are listed in the table below.

Rate Review - Year Five Services	
Pediatric Personal Care (PPC)	Speech Therapy
Home Health Services	Physical and Occupational Therapy (PT/OT)
Private Duty Nursing (PDN)	Prosthetics, Orthotics, and Supplies (POS)
Pediatric Behavioral Therapy (PBT)	Vision

The Rate Review Process is informed by rate benchmark comparisons, access analyses, stakeholder feedback, and Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback.

This report contains a summary of findings, key considerations, and Department recommendations for each service.

Medicare rates were used as the primary rate benchmark for four of the eight categories of service: Speech Therapy, PT/OT, POS, and Vision. Service rates paid by an average of comparable Medicaid states were used as the benchmark comparison for PPC, Home Health Services, PDN, and PBT.[1]

The Departments recommendations for each service grouping are summarized below.

Pediatric Personal Care

The Department found the payment rate for PPC services was 134.35% of the benchmark; Colorado payments varied between 109.48% and 140.57% of five other states' Medicaid rates.

The Department recommends:

1. Continuing outreach efforts to Home and Community-Based Services (HCBS) class B licensed providers to alert them that PPC State Plan services are allowable and billable by license type.

Home Health Services

The Department found payment rates for home health services were 101.72% of the benchmark; payments varied between 76.04% and 348.53% of the benchmark.

The Department recommends:

1. Continuing the project initiated in October 2020 to investigate equity across similar services (e.g., consider home health speech therapy rates and outpatient speech therapy rates). [2, 3, 4, 5]

2. Utilizing EVV data, after it is available in Spring 2021, to further evaluate the current home health therapy unit payment methodology and minimum duration requirements.[6]

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[1] For more information regarding benchmarks, including benchmark descriptions and methodologies, see the 2020 Medicaid Provider Rate Review Analysis Report.
[2] This project is projected to conclude in Spring 2021.
[3] This recommendation aligns with the second speech therapy recommendation.
[4] This recommendation may require additional resources, such as future budget requests.
[5] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.
[6] This recommendation may require additional resources, such as future budget requests.

Private Duty Nursing (PDN)

The Department found payment rates for PDN services were 98.15% of the benchmark; payments varied between 74.08% and 102.03% of the benchmark.

The Department recommends:

1. Investigating rate equity across similar services, provided through other benefits or in other settings, to identify services that would benefit from a rate change (e.g., consider home health Registered Nurse/Licensed Practical Nurse (RN/LPN) rates and PDN RN/LPN rates).[7, 8]

Pediatric Behavioral Therapy (PBT)

The Department found payment rates for PBT services were 92.90% of the benchmark; payments varied between 85.99% and 94.31% of the benchmark.

The Department recommends:

1. Seeking federal approval to make PBT a State Plan benefit.
2. Continuing to support internal efforts to recruit and retain providers of PBT services and promote access to care.

Speech Therapy

The Department found payment rates for speech therapy services were 73.51% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 16.82% and 107.20% of the benchmark.

The Department recommends:

1. Rebalancing speech therapy rates and evaluating individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[9, 10]
2. Continuing the project initiated in October 2020 to investigate equity across similar services (e.g., consider home health speech therapy rates and outpatient speech therapy rates).[11, 12, 13, 14]

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[7] This recommendation may require additional resources, such as future budget requests.
[8] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.
[9] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[10] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.
[11] This project is projected to conclude in Spring 2021
[12] This recommendation aligns with the first home health services recommendation.
[13] This recommendation may require additional resources, such as future budget requests.
[14] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.

Physical and Occupational Therapy (PT/OT)

The Department found payment rates for PT/OT services were 86.41% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 28.06% and 793.16% of the benchmark.

The Department recommends:

1. Rebalancing PT/OT rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[15, 16]

Prosthetics, Orthotics, and Supplies (POS)

The Department found payment rates for POS services were 80.80% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 4.46% and 1,233.91% of the benchmark.

The Department recommends:

1. Rebalancing POS rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[17, 18]

Vision

The Department found payment rates for vision services were 81.13% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 25.06% and 190.56% of the benchmark.

The Department recommends:

1. Rebalancing vision rates and will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[19, 20]

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[15] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

[16] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.

[17] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

[18] This recommendation partially aligns with the Governor's November 1, 2020 budget request, R-16, "Benchmark Certain Rates to Medicare." The Department will consider completing this recommendation in alignment with future budget requests.

[19] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

[20] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will

Introduction

The Colorado Department of Health Care Policy & Financing (the Department) administers the State's public health insurance programs, including Health First Colorado (Colorado's Medicaid Program), Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. The Department's mission is to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources.

In 2015, the Colorado State Legislature adopted Senate Bill 15-228 "Medicaid Provider Rate Review," an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with Colorado Revised Statutes (CRS) 25.5-4-401.5, the Department established an evidence-based Rate Review Process that involves four components:

- assess and, if needed, review a five-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review and present the findings in a report published the first of every May;
- develop strategies for responding to the analysis results; and
- provide recommendations on all rates reviewed and present them in a report published the first of every November.

The Rate Review Process is informed by the MPRRAC and stakeholders, who participate via public quarterly meetings and written communication. The MPRRAC and stakeholders provide feedback to the Department on its analyses and recommendations, which are later published in reports by the Department.

MPRRAC meetings for Year Five services of the five-year rate review cycle began in November 2019 and concluded in September 2020. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are on the Department website.

On May 6, 2020, the Department published the 2020 Medicaid Provider Rate Review Analysis Report.

Report Purpose

This document serves as the second report in the annual Rate Review Process. It briefly summarizes what was learned through the Rate Review Process, the Department's recommendations for services reviewed in Year Five, and considerations taken in developing recommendations.

The Department's recommendations were informed by the 2020 Medicaid Provider Rate Review Analysis Report, as well as MPRRAC and stakeholder feedback. They were developed after working with the Office of State Planning and Budgeting (OSPB) to determine priorities and achievable goals within the statewide budget.

This report is intended to be used by the Joint Budget Committee (JBC) for consideration in formulating the budget for the State Department.

identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.

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 helped inform the Department's payment philosophy for fee-for-service (FFS) rates.

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

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

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

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

- budget constraints that may prevent payment at a certain amount;
- investigating whether a rate change could create distributional problems that may negatively impact individual providers and developing feasible mitigation strategies;
- identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and
- developing systems to ensure that payments are associated with high-quality provision of services.

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

Format of Report

This report has eight sections: PPC, Home Health Services, PDN, PBT, Speech Therapy, PT/OT, POS, and Vision. Each section contains the following sections.

Summary of Findings

This section provides a summary of the Department's findings through the Rate Review Process, which includes rate comparison and access analyses.

Key Considerations

This section provides a summary of the information and data that informed the development of the Department's recommendations, including MPRRAC and stakeholder feedback.

The Rate Review Process is an evidence-based process in which all MPRRAC and stakeholder feedback is valuable for informing Department work. The Department is committed to thoroughly and thoughtfully evaluating available evidence and MPRRAC and stakeholder feedback to make evidence-based decisions and recommendations.

Department Recommendations

This section lists the Department's recommendations for Year Five services as a result of the Rate Review Process.

The Department recognizes that while the process of data analysis and standardized reporting is optimal for identifying outliers, this type of high-level analysis often leads to insights that require further in-depth research to investigate the reasons behind the data outliers and which mechanism is appropriate for intervention (e.g., rates, policy, etc.). Additionally, stakeholder feedback 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.

Pediatric Personal Care

Summary of Findings

Analyses suggest that PPC payments at 134.35% of the benchmark were sufficient to allow for member access and provider retention.[21] Colorado as a percentage of five other states' Medicaid rates ranged from 109.48%-140.57%.[22]

Key Considerations

Stakeholder Feedback

- There is a reportedly low availability of active providers of PPC services for Medicaid members.
- Low wages are paid to PPC caregivers.
- The effect of different state minimum wages on the rate comparison.

Additional Considerations

- The PPC benefit only refers to State Plan Pediatric Personal Care services for members under the age of 20 that qualify for one of 17 personal care tasks.[23]
- PPC services are performed by a non-medically trained caregiver in the member's home.
- Members seeking PPC services are often directed by home health agencies to Long-Term Home Health (LTHH) services provided by licensed home health agencies.
- PPC service rates were compared to an average of other states' Medicaid rates[24]; Colorado, Florida, and Texas are the only states that reimburse for pediatric-specific personal care services.

Department Recommendations

1. The Department recommends continuing outreach efforts to Home and Community-Based Services (HCBS) class B licensed providers to alert them that PPC State Plan services are allowable and billable by license type.

[21] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[22] States used in the PPC rate comparison analysis were California, Florida, Idaho, Louisiana, and Texas.
[23] See the Pediatric Personal Care Services web page for a list of the 17 personal care tasks. The PPC benefit does not include personal care services provided through Home and Community-Based Services (HCBS) Waivers; see the Home and Community-Based Services web page for more information. HCBS waiver services are scheduled to be reviewed in 2021; for more information, see the Updated Rate Review Five-Year Schedule.
[24] States used in the PPC rate comparison analysis were California, Florida, Idaho, Louisiana, and Texas. Florida and Texas were included because they had pediatric-specific rates to which we could compare Colorado rates. California, Idaho, and Louisiana have been included in previous analyses as reasonable comparators.

Home Health Services

Summary of Findings

Analyses suggest home health payments at 101.72% of the benchmark were sufficient to allow for member access and provider retention.[25] The individual rate ratios were 76.04%-348.53% of the benchmark.

Key Considerations

Stakeholder Feedback

- If more home health caregivers were available, more members could leave the hospital setting earlier.
- The home health fixed rate does not have a minimum duration requirement for services.
- Agencies are having difficulty hiring caregivers; providers suggest the current rate is the reason.
- Aligning with Medicare is insufficient due to the short-term nature of Medicare Home Health services.
- Rates should be set at 90% of the Medicare Low Utilization Payment Adjustment (LUPA) rates for home health services.
- Electronic Visit Verification (EVV) requirements will discourage smaller providers from delivering Home Health services.
- Home health speech therapy rates are fair when compared to stand alone outpatient speech therapy rates (which are seen as inequitable).

Additional Considerations

- Unit values vary from state-to-state; Colorado visits are either one hour or two and a half hours per visit, compared to other states that reimbursed based on various unit values (e.g., 15-minute increments, single-unit untimed visits, etc.).[26]
- Colorado is one of four states[27] with both a home health basic and extended rate.
    - The rate comparison shows that Colorado Medicaid pays $38.12 for the home health basic rate, which is for the initial one-hour visit; this rate is 76.04% of the benchmark average.
    - Colorado Medicaid balances out the lower basic rate with additional reimbursement for visits lasting more than one-hour with the home health extended rate, which pays an additional $11.39 for each extended unit of 15-30 minutes; this rate is 348.53% of the benchmark.
    - Further analysis reveals that both the basic and extended CPT codes are billed on 89% of claims (for claims data from March 2017 through June 2019).

[25] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[26] These differences are accounted for in the rate comparison analysis; see Appendix B in the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[27] Other states that include both basic and extended home health rates on their fee schedules are Louisiana, Nebraska, and Ohio.

    - This payment methodology and accompanying claims data suggests Colorado Medicaid reimburses more accurately based on the length of the visit, compared to other states that only pay a basic rate for a visit of any length, especially since 89% of visits lasted more than one-hour (e.g., the extended CPT code was present on the claim).
- A previous assessment by the Department concluded that LUPA is not an appropriate comparator for home health rates due to differences in client eligibility, utilizer characteristics, and unit designations.[28, 29]
- EVV is a federal requirement mandated by the 21st Century CURES Act; the Department has worked closely with stakeholders to ensure the option of a state system that meets the needs of providers and members, while also complying to the requirements established by the Centers for Medicare and Medicaid Services (CMS).
- EVV is now live; EVV will be tied to claims starting in January 2021 and data will be available for future years of review. It should be noted that there will be a live-in caregiver exemption, which may limit the data the Department receives from EVV for home health services.
- The Department received information that some home health agencies merged with other agencies, which led to a perceived decrease in active providers, but did not have an impact on the actual number of agencies providing home health services; therefore, access was not negatively impacted.
- Home health services received 1% across-the-board (ATB) rate increases in July 2018, July 2019, and July 2020.
- In 2017, the following home health services received a Targeted Rate Increase (TRI) of 6.01-6.02%:
    - Registered Nurse (RN)
    - Occupational Therapy
    - Physical Therapy
    - Speech Therapy

Department Recommendations

1. The Department recommends continuing the project initiated in October 2020 to investigate equity across similar services (e.g., consider home health speech therapy rates and outpatient speech therapy rates).[30, 31, 32, 33]

[28] See page 14-15 of the 2016 Medicaid Provider Rate Review Recommendation Report for more information.
[29] The Joint Budget Committee (JBC) allocated funding to the Department to bring rates to 30% of Medicare LUPA, stating that funding would be provided in the following two years to bring rates to 60% and then 90% of Medicare LUPA rates. However, the Department only received funding for the first year.
[30] This project is projected to conclude in Spring 2021.
[31] This recommendation aligns with the second speech therapy recommendation.
[32] This recommendation may require additional resources, such as future budget requests.
[33] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.

2. The Department recommends utilizing EVV data, after it is available in Spring 2021, to further evaluate the current home health therapy unit payment methodology and minimum duration requirements.[34]

[34] This recommendation may require additional resources, such as future budget requests.

Private Duty Nursing (PDN)

Summary of Findings

Analyses suggest that PDN payments at 98.15% of the benchmark were sufficient to allow for member access and provider retention.[35] The individual rate ratios were 74.08%-102.03% of the benchmark.

Key Considerations

Stakeholder Feedback

- Licensed Practical Nurse (LPN) rates are too low to be competitive; concerns were raised regarding untapped potential in recruiting LPNs for PDN providers servicing Colorado Medicaid members.
- Other states' Medicaid rates may not be a good comparator for PDN rates.
- Children are reportedly remaining in the hospital longer than necessary because of a lack of available in-home services necessary for discharge.

Additional Considerations

- The LPN rate received a 7.24% TRI in 2017; data from before and after the TRI showed utilization was unaffected.
- The Department's rate setting process considers operational costs, which includes costs such as staff wages, benefits, rental, and utility costs, etc. Cost reporting, which is not available to the Department, would further inform rate setting efforts; however, the Department has not been offered these reports.
- LPN rates for different settings, such as hospitals, are based on numerous factors including, but not limited to, job complexity and average patient load.
- Individually, the LPN rate for PDN services is 96.98% of other states' average Medicaid rate and the RN rate for PDN services is 102.03% of other states' average Medicaid rate.
- Unit values for PDN services in Colorado are based on one hour per unit, compared to other states that reimburse based on various unit values (e.g., 15-minute increments, single-unit untimed visits, etc.).[36]

Department Recommendations

1. The Department recommends investigating rate equity across similar services, provided through other benefits or in other settings, to identify services that would benefit from a rate change (e.g., consider home health Registered Nurse/Licensed Practical Nurse (RN/LPN) rates and PDN RN/LPN rates).[37, 38]

[35] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[36] These differences are accounted for in the rate comparison analysis; see Appendix B in the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[37] This recommendation may require additional resources, such as future budget requests.
[38] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.

Pediatric Behavioral Therapy (PBT)

Summary of Findings

Analyses suggest that PBT payments at 92.90% of the benchmark were sufficient to allow for member access and provider retention.[39] The individual rate ratios were 85.99%-94.31% of the benchmark.

Key Considerations

Stakeholder Feedback

- The impact of transitioning PBT from a waiver service to an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service was a perceived rate cut for providers.
- The increased complexity of requirements for EPSDT providers is impacting provider retention.
- There is a disruption of services when members reach age 21 because they must transition from EPSDT services to waiver services.

Additional Considerations

- The reimbursement rates for PBT services remained consistent in the transition from waiver to EPSDT services.
- The Department proactively recruited providers once PBT transitioned to EPSDT. There are currently 431 providers now rendering PBT services, compared to only 88 providers that were enrolled as Behavioral Services providers through the Children's Extensive Supports (CES) and Children with Autism (CWA) waivers.
- Colorado is currently the only state offering pediatric-specific rates for behavioral therapy.
- There are no additional requirements necessary for enrolled providers to provide EPSDT services.
- Prior Authorization Request (PAR) processes are similar across services that require PARs.
- Members should work with the Case Management Agency (CMA) to transition services when approaching 21 years of age.

Department Recommendations

1. The Department recommends seeking federal approval to make PBT a State Plan benefit.
2. The Department recommends continuing to support internal efforts to recruit and retain providers of PBT services and promote access to care.

[39] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.

Speech Therapy

Summary of Findings

Analyses were inconclusive to determine if outpatient speech therapy payments at 73.51% of the benchmark were sufficient to allow for member access and provider retention.[40] The individual rate ratios were 16.82%-107.20% of the benchmark.

Key Considerations

Stakeholder Feedback

- Outpatient speech therapy rates are considered by stakeholders as insufficient to offer competitive staff wages, retain specialized providers, or cover overhead and administrative costs, which could lead to a limitation in services available to Medicaid members.
- Outpatient speech therapy rates are significantly lower than home health speech therapy rates, though stakeholders report that both provider groups require similar levels of training and expertise.
- The feeding therapy rate is very low.
- Low rates are reportedly having a disproportionate impact on children of color.
- The Department should consider changing to timed or incremental unit values for outpatient speech therapy services.

Additional Considerations

- Utilization trends in data indicate migration of services from individual providers to home health agencies, who provide a wider range of services for individuals needing more comprehensive home health care.
- Home health agencies have more requirements and administrative costs compared to individual providers, which are factored into home health service rates.
- Most therapy service visits include provision of more than one service.
- Outpatient speech therapy rates could not be rebalanced in a budget-neutral manner as previously recommended in the 2017 Medicaid Provider Rate Review Recommendation Report; rebalancing would have required additional funds.[41]

[40] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[41] The Department did not receive funding in the 2018 Long Bill to rebalance speech therapy rates; rates could not be rebalanced without impacting the budget.

Department Recommendations

1. The Department recommends rebalancing outpatient speech therapy rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[42, 43]
2. The Department recommends continuing the project initiated in October 2020 to investigate equity across similar services (e.g., consider home health speech therapy rates and outpatient speech therapy rates).[44, 45, 46, 47]

[42] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[43] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.
[44] This project is projected to conclude in Spring 2021.
[45] This recommendation aligns with the first home health services recommendation.
[46] This recommendation may require additional resources, such as future budget requests.
[47] There is no currently available information. The Department will complete an analysis project to evaluate stakeholder feedback regarding equity across services.

Physical and Occupational Therapy (PT/OT)

Summary of Findings

Analyses suggest that PT/OT payments at 86.41% of the benchmark were sufficient to allow for member access and provider retention.[48] The individual rate ratios were 28.06%-793.16% of the benchmark.

Key Considerations

Stakeholder Feedback

- The Physical Therapy Association of Colorado has been trying to get a rate increase directly through the JBC for several years.
- Providers are unwilling to accept Medicaid patients because the rates are too low.
- The increased usage of telemedicine visits during the pandemic has had a positive impact on PT/OT servicing, but COVID has caused job loss as well.
- Colorado is the only state to assign different rates to the three increasing complexity evaluation codes. Medicare did not assign different values, intending to assess utilization before determining rates.

Additional Considerations

- Data shows utilization, rendering providers, and expenditures are increasing for PT/OT services, suggesting PT/OT providers are willing to accept Medicaid patients.[49]
- Data suggests utilization has increased for all three increasing complexity evaluation codes, suggesting proper use of complexity indicators[50]; there is an absence of evidence that access to care was impacted by this rate change.
- Most visits for therapy services include provision of more than one service.

Department Recommendations

1. The Department recommends rebalancing PT/OT rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[51, 52]

[48] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[49] See the 2020 Medicaid Provider Rate Review Analysis Report for more information; the Department acknowledges there may be other opportunities to improve access to care and provider retention.
[50] See Appendix D in the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[51] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[52] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.

Prosthetics, Orthotics, and Supplies (POS)

Summary of Findings

Analyses suggest that POS payments at 80.80% of the benchmark were sufficient to allow for member access and provider retention.[53] The individual rate ratios were 4.46%-1,233.91% of the benchmark.

Key Considerations

Stakeholder Feedback

- Several supplies, especially those for pediatric patients, are not covered by Medicare, due to the difference in populations served by Medicare.
- Providers request an increase to at least 80% of Medicare rates, and 90% would be preferred.

Additional Considerations

- Medicare was the primary payor used for the rate comparison analysis; where a Medicare comparison was unavailable, the rate was compared with other states' Medicaid rates.
    - Medicare rates for supplies are comparable due to the nature of the benefit.
    - The rates compared to other states' Medicaid rates provide insight to how we compare on reimbursement for supplies that are not covered by Medicare.
- Data analyses did not include out-of-state claims including those from border towns and mail-order utilization.

Department Recommendations

1. The Department recommends rebalancing POS rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[54, 55]

[53] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[54] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[55] This recommendation partially aligns with the Governor's November 1, 2020 budget request, R-16, "Benchmark Certain Rates to Medicare." The Department will consider completing this recommendation in alignment with future budget requests.

Vision

Summary of Findings

Analyses suggest that vision payments at 81.13% of the benchmark were sufficient to allow for member access and provider retention.[56] The individual rate ratios were 25.06%-190.56% of the benchmark.

Key Considerations

Stakeholder Feedback

- There was a large increase in provider enrollment for vision services following a rate increase five years ago; for this reason, a decrease in rates could have a negative impact on provider retention.

Additional Considerations

- The Department did not have any feedback regarding vision services or rates.

Department Recommendations

1. The Department recommends rebalancing vision rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[57, 58]

[56] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[57] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable and consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[58] This recommendation does not have a corresponding item in the Governor's November 1, 2020 budget request due to the current budget deficit; the Department will consider this recommendation for future budget requests. The Department will identify any immediate changes that can be made in a budget neutral manner by the end of FY 2020-21 and will implement them upon federal approval.