COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 8, 2021

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: Emergency Medical Transportation (EMT), Non-Medical Transportation (NEMT), Home- and Community-Based Services (HCBS) Waivers, and Targeted Case Management (TCM), under review in year one (cycle two) 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): 2021 Medicaid Provider Rate Review Recommendations Report

Cc: Dixie Melton, Vice-chair, Medicaid Provider Rate Review Advisory Committee
Melissa Benjamin, Medicaid Provider Rate Review Advisory Committee
David Friedenson, Medicaid Provider Rate Review Advisory Committee
Rob Hernandez, Medicaid Provider Rate Review Advisory Committee
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2021 Medicaid Provider Rate Review Recommendation Report

November 8, 2021

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

COLORADO
Department of Health Care Policy & Financing

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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 One (2021) of the second five-year review cycle (2021-2025) are listed in the table below.

Rate Review - Year One Services	
Emergency Medical Transportation (EMT)	Waiver for Persons with Spinal Cord Injury (SCI)
Non-Emergent Medical Transportation (NEMT)	Waiver for Children with Life Limiting Illnesses (CLLI)
Waiver for Persons with Brain Injury (BI)	Children's Extensive Support Waiver (CES)
Waiver for Persons with Developmental Disabilities (DD)	Children's Habilitative Residential Program (CHRP)
Supported Living Services Waiver (SLS)	Children's Home and Community-Based Services Waiver (CHCBS)
Community Mental Health Supports Waiver (CMHS)	Home and Community-Based Services (HCBS) Waivers and Waiver Services in Aggregate
Elderly, Blind, and Disabled Waiver (EBD)	Targeted Case Management (TCM)

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 three of the six categories of service: EMT, NEMT, and TCM. Service rates paid by an average of comparable Medicaid states were used as the benchmark comparison for HCBS Waivers (adult, children, and aggregate).[1]

The Departments recommendations for each service grouping are summarized below.

Transportation Services

Emergency Medical Transportation (EMT)

The Department found the payment rate for EMT services was 40.92% of the benchmark; Colorado payments varied between 29.44% and 99.51% of five other states' Medicaid rates.

The Department recommends:

1. Increasing EMT services rates to 80% of the benchmark.[2, 3]

2. Evaluating the authority to develop and implement an EMS treat-in-place model for Health First Colorado EMS providers.[4, 5]

[1] For more information regarding benchmarks, including benchmark descriptions and methodologies, see the 2021 Medicaid Provider Rate Review Analysis Report.
[2] This recommendation partially aligns with R-10 in the 2021 Governor's Budget Request. Any rate changes will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022.
[3] See page 10 for more information detailing Department best practices for the Rate Review Process.
[4] This recommendation may require additional resources.
[5] See pages 12-13 for more information on the treat-and-release model, including definitions, stakeholder feedback, and the Department's current work in this area.

3. Continuing to pursue opportunities for policy development, working with community partners to understand current practices and community needs.[6]

Non-Emergent Medical Transportation (NEMT)

The Department found payment rates for NEMT services were 37.51% of the benchmark; payments varied between 27.06% and 134.51% of the benchmark.

The Department recommends:

1. Increasing NEMT services rates to 80% of the benchmark.[7, 8]

2. Continuing to monitor transportation claims data and utilization trends to identify if there is an ongoing issue related to the COVID-19 pandemic, and the impact, if any, on access to care and provider retention.[9, 10]

3. The Department continue to study the rate adjustments needed to respond to the September 2021 NEMT audit performed by the Office of the State Auditor, with a noted evaluation of the rates needed in rural Colorado under the emerging new structure (IntelliRide serving nine Front Range counties, with transportation providers serving the remaining 55 counties in the state).

Home- and Community-Based Services (HCBS) Waivers

Please note that HCBS rates and payment methodologies are notoriously hard to measure, analyze, and compare. Please see the introduction in the HCBS section within this report for more information and background, including information on the sufficiency of HCBS rates.

Adult HCBS Waivers

The Department found payment rates for Adult HCBS Waiver services were:[11]

- 98.12%-164.44% of the benchmark for BI payments;
- 72.91%-151.36% of the benchmark for DD payments;
- 52.82%-131.95% of the benchmark for SLS payments;
- 46.65%-112.93% of the benchmark for CMHS payments;
- 79.48%-113.20% of the benchmark for EBD payments; and
- 81.12%-95.24% of the benchmark for SCI payments.

Individual service payments varied between 35.07% and 351.23% of the benchmark. Please see the introduction in the full section within this report for more information.

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[6] The Department is currently investigating opportunities for Emergency Medical Services (EMS) to support and provide community service needs.
[7] This recommendation partially aligns with R-10 in the 2021 Governor's Budget Request. Any rate changes will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022.
[8] See page 10 for more information detailing Department best practices for the Rate Review Process.
[9] The Department is currently collecting this data and will monitor for up to a minimum of 24 months, at which point the Department will evaluate the need to continue monitoring transportation data.
[10] See page 14 for more information on how NEMT services may have been impacted by COVID-19.
[11] These benchmarks only indicate the aggregate rate comparison for each individual waiver; for more details on rate benchmarks for individual services under adult waivers, see the 2021 Medicaid Provider Rate Review Analysis Report.

The Department recommends:

1. Seeking authority to implement the results of a recent Transitional Living Program (TLP) rate setting project.[12, 13]
2. Evaluation of tiered rate reimbursement development for Alternative Care Facilities (ACFs) to support higher need members in the community.[14, 15]

Children's HCBS Waivers

The Department found payment rates for Children's HCBS Waiver services were:[16]

- 58.42-286.04% of the benchmark for CLLI payments;
- 68.19%-211.19% of the benchmark for CES payments;
- 67.97%-306.81% of the benchmark for CHRP payments; and
- 34.37%-143.64% of the benchmark for CHCBS payments.

Individual service payments varied between 34.37% and 307.81% of the benchmark. Please see introduction in the full section within this report for more information.

The Department recommends:

1. Further increasing the CHRP foster care home rates to align with DD waiver host home rates.[17, 18]
2. Adding host homes as a residential provider type for members ages 18 and under to increase facility capacity limits and provider capacity.[19, 20]
3. Aligning respite service limits provided under the CHRP waiver with respite service limits under the CES waiver.[21, 22]

[12] The Department is currently working on this project; the Department is seeking state and federal authority to implement new TLP rate(s), with a projected implementation date of January 1, 2023. This recommendation may require further resources.
[13] See pages 16-17 for more information on TLP and context behind this recommendation.
[14] See the APRA HCBS Funding Plan Overview for more information. Rate changes, if any, will be implemented upon state and federal approval. This recommendation may require additional resources.
[15] See pages 16-17 for more information, including stakeholder feedback, on the ACF per diem rate.
[16] These benchmarks only indicate the aggregate rate comparison for each individual waiver; for more details on rate benchmarks for individual services under children's waivers, see the 2021 Medicaid Provider Rate Review Analysis Report.
[17] This recommendation aligns with R-10 in the 2022 Governor's Budget Request; this recommendation will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023.
[18] See pages 19-20 for more information regarding the recent change in eligibility requirements for CHRP waiver services.
[19] This recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023. This recommendation may require additional resources.
[20] See page 19 for more information regarding stakeholder feedback for residential services available to members ages 18 and under.
[21] This recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023. This recommendation may require additional resources.
[22] See pages 19-20 for more information regarding respite services on Children's waivers.

Aggregate Waivers and Waiver Services

The Department found payment rates for aggregate HCBS waiver services were 97.7% of the benchmark; payments varied between 34.37% and 351.23% of the benchmark. Please see introduction in the full section within this report for more information.

The Department recommends:

1. Prioritizing efforts to stabilize and strengthen the long-term care direct care workforce.
2. Aligning rates for services that span multiple waivers.[23, 24]
3. Pursuing the implementation of geographic rate modifiers for waiver services to address disparities of provider capacity across the state.[25, 26]
4. Further investigation of respite services, including provider capacity and retention, and access to respite services across populations.[27, 28]
5. A minimum of a 10% rate increase in order to support the lowest paid direct-care workers to the following services:[29]
    - ACF per diem rate;
    - Adult day;
    - Consumer-Directed Attendant Support Services (CDASS) HMA, CDASS personal care, and CDASS homemaker;
    - Day habilitation;
    - Group Residential Support Services (GRSS);
    - Homemaker (basic and enhanced);

[23] This will include bringing the massage rate on CLLI and SCI waivers to match the SLS rate, which aligns with R-10 in the 2022 Governor's Budget Request. The Department has identified several other services, such as Non-Medical Transportation (NMT), that span multiple waivers but are set at different rates across waivers. This recommendation may require additional resources. These rate changes, if any, will be implemented upon state and federal approval.
[24] See page 21 for more information on the context behind this recommendation.
[25] The Department is currently working on developing an implementation project plan that will be shared with stakeholders at a future time; this will be a long-term, multi-step project and may require additional resources, in addition to CMS approval and an update to the MMIS.
[26] See page 20 for more information regarding stakeholder feedback on rural and Denver metro area rate differences.
[27] This includes investigating the impact of overnight respite, how to increase providers, and the impact of not having in-home respite available under the CMHS waiver. The Department is currently hiring for this project and plans to have more information on the scope and desired outcomes of this research by Fall 2022.
[28] See pages 18, 20-21 for more information on respite services and context behind this recommendation.
[29] This recommendation partially aligns with R-10 in the 2022 Governor's Budget Request. These rate changes, if any, will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023. These recommended rate changes are based on the following: (a) services that are tied to the direct care workforce issues noted in Appendix H of the 2021 Medicaid Provider Rate Review Analysis Report; (b) current significant budget neutrality percent of the following services: ACF - 25.4%; Individual Residential Support Services - 58.26% to 24.48%, Group Residential Support Services (GRSS) - 40.11% to 10.81%; personal care (EBD, CMHS, BI, SCI) - 24.62%; personal care (SLS) - 17.66%; homemaker (EBD,CMHS, SCI and basic homemaker for SLS) - 4.91%; enhanced homemaker (SLS) - -2.78%; (c) adult day and day habilitation services identified by stakeholder feedback and confirmed in rates and access to care analyses. This recommendation may require additional resources. Any further rate changes will be implemented upon state and federal approval.

- Individual Residential Support Services (IRSS);
- In-Home Support Services (IHSS) Health Maintenance Activities (HMA), IHSS personal care, and IHSS homemaker; and
- Personal care.

Targeted Case Management (TCM)

The Department found payment rates for TCM services were 87.84% of the benchmark; payments varied between 66.52% and 102.95% of the benchmark.

The Department recommends:

1. Continuing support to the Case Management Redesign project/team to ensure the project/team considers all stakeholder perspectives, as well as evidence-based data that can be used to inform project initiatives.[30]

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 equity, access and outcomes for the people it serves while saving Coloradans money on health care and driving value for Colorado.

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 One (Cycle Two) services of the five-year rate review cycle began in November 2020 and concluded in September 2021. 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 2021 Medicaid Provider Rate Review Analysis Report.

[30] For more information, see the Case Management Redesign web page.

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 One (Cycle Two), and considerations taken in developing recommendations.

The Department's recommendations were informed by the 2021 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.

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., HCBS Waivers).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g., pediatric services).
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., TCM).
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 six sections: Emergency Medical Transportation (EMT) Services, Non-Emergent Medical Transportation (NEMT) Services, Adult Home and Community-Based Services (HCBS) Waivers, Children's HCBS Waivers, Aggregate HCBS Waivers & Waiver Services, and Targeted Case Management (TCM). 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 One (Cycle Two) 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.

Emergency Medical Transportation (EMT) Services

Summary of Findings

Analyses suggest that EMT payments at 40.92% of the benchmark were sufficient to allow for member access and provider retention; however, current rates may not support appropriate reimbursement for high-value services.[31] The individual rate ratios were 29.44%-99.51% of the benchmark.

Key Considerations

Stakeholder Feedback

- EMT rates are among the lowest for service groupings reviewed through the Medicaid Provider Rate Review Process.
- EMT services have a high readiness cost compared to other services due to the requirements that emergency vehicles be staffed with trained service delivery providers and stocked with any medical equipment that may be required.
- There have been small incremental rate increases for particular EMT services, but not any noticeable, significant increases in reimbursement.
- Providers appreciate collaboration with the Department on policies and the supplemental payment program since 2016 but indicate there are still gaps in reimbursement for EMT service providers.
- Providers report that EMT/Emergency Medical Service (EMS) providers see many more Medicaid patients than is recorded in claims data because treat-and-release services are not reimbursed for EMT/EMS providers.[32] For this reason, providers request that the Department consider adding an EMS treat-and-release model as a covered benefit.[33]

Additional Considerations

- Since EMT services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report, both total members accessing EMT services and total active EMS providers increased. In addition, total expenditures increased by over $12 million.[34]
- As a result of the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of EMT services, effective July 2017.[35]
- Effective January 1, 2018, the Department amended the Colorado State Plan to create an EMT Supplemental Payment program that allows eligible EMS providers to receive an annual supplemental payment for the uncompensated costs incurred by providing ground or air emergency medical transportation services to Medicaid beneficiaries. Data indicates the

[31] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.
[32] Current policy requires EMT providers to complete transport of a member to a health care facility to be reimbursed by Medicaid.
[33] Treat-and-release model refers to "the onsite (at the scene) treatment of a patient by a responding trained paramedic without either transporting that patient to a healthcare facility… or referring that patient to a healthcare facility." Citation: Emergency Medical Service "Treat and Release" Protocols: A Review of Clinical and Cost-Effectiveness, Safety, and Guidelines [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2014 May 27. CONTEXT AND POLICY ISSUES. Available from: https://www.ncbi.nlm.nih.gov/books/NBK264086/.
[34] For more information, see the 2016 Medicaid Provider Rate Review Analysis Report.
[35] EMT services received a Targeted Rate Increase (TRI) of 6.61%, effective July 2018.

supplemental payment program provided 43 participating providers with $11 million in supplemental reimbursement in FY 2017-18, and provided 63 providers with $26 million in supplemental reimbursement in FY 2018-19.[36]

- The Department is currently reviewing its authority to establish an EMS treat-and-release model as a covered benefit to address pay inequities for transportation services, as well as part of the Department's effort in pursuing opportunities for health care community integration.[37]
- The total number of active providers does not represent the total number of service delivery providers employed by agencies providing EMT services.

Department Recommendations

1. The Department recommends a rate increase for EMT services to bring them to 80% of the benchmark.[38, 39]

2. The Department recommends evaluating the authority to develop and implement an EMS treat-in-place model for Health First Colorado EMS providers.[40]

3. The Department recommends continuing to pursue opportunities for policy development, working with community partners to understand current practices and community needs.[41]

Non-Emergent Medical Transportation (NEMT) Services

Summary of Findings

Analyses suggest NEMT payments at 37.51% of the benchmark were sufficient to allow for member access and provider retention; however, current rates may not support appropriate reimbursement for high-value services.[42] The individual rate ratios were 27.06%-134.51% of the benchmark.

Key Considerations

Stakeholder Feedback

- Providers indicate that rates are reportedly too low to ensure provider retention and appropriate access to high-value services.

[36] For more information, see the Public Emergency Medical Services Supplemental Payment web page.
[37] More information about community integration of health care services in Colorado, see the CDHPE Community Integration web page.
[38] This recommendation partially aligns with R-10 in the 2022 Governor's Budget Request. Rate changes, if any, will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022.
[39] See page 10 for more information detailing Department best practices for the Rate Review Process.
[40] This recommendation may require additional resources.
[41] The Department is currently investigating opportunities for Emergency Medical Services (EMS) to support and provide community service needs.
[42] See the 2021 Medicaid Provider Rate Review Analysis Report for more information.

Additional Considerations

- Both total members accessing NEMT services and total active NEMT providers increased since these services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report. In addition, total expenditures increased by over $40 million.[43]
- The average penetration rate for four counties (Moffat, Routt, Jackson, and Rio Blanco) significantly increased from below the state average in FY 2014-15 to above the state average in CY 2019.[44]
- As a result of the rate review team working with the Governor's Office in response to the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of NEMT services, effective July 2017.[45]
- NEMT providers are provided a brokerage fee by the Department, which is subject to contracted value-based obligations that may impact total fee reimbursed to the provider.[46]
- Many Medicaid recipients in rural areas are already vehicle-dependent due to the lack of public transportation infrastructure, which may impact use of NEMT services in those regions.
- Data, collected after the CY 2019 base data, suggests transportation services may have been disproportionately impacted by the COVID-19 pandemic, and further impacted by the evolving and increasing use of telemedicine services.[47]
- The total number of billing providers does not represent the total number of service delivery providers employed by agencies providing NEMT services.
- The Office of the State Auditor released its NEMT audit findings in September 2021. Those findings were numerous and included many opportunities, which the Department continues to respond to. Rate adjustments are likely necessary in addressing the audit findings, especially to address the challenges in rural communities. Specifically, the Department is amending its NEMT contract with its vendor IntelliRide so that it no longer administers NEMT statewide and will only serve nine Front Range counties. Transportation providers will serve the remaining 55 counties in the state.

Department Recommendations

1. The Department recommends a rate increase for NEMT services to bring them to 80% of the benchmark.[48, 49]

[43] Total member count, provider count, and paid dollars from the 2016 Medicaid Provider Rate Review Analysis Report is based on claims data from FY 2014-15, which does not include expenditures from July 2014- November 2014 because the previous broker did not submit claims into the MMIS.
[44] Penetration rate averaged 0.9 in these four counties in FY 2014-15 and 5.88 in CY 2019.
[45] NEMT services also received a TRI of 6.61%, effective July 2018.
[46] For more information, see the NEMT web page.
[47] For more information, see Appendix J in the 2021 Medicaid Provider Rate Review Analysis Report.
[48] This recommendation partially aligns with R-10 in the 2022 Governor's Budget Request. Rate changes, if any, will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022. Any rate changes will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022.
[49] See page 10 for more information detailing Department best practices for the Rate Review Process.

2. The Department recommends continuing to monitor transportation claims data and utilization trends to identify if there is an ongoing issue related to the COVID-19 pandemic, and the impact, if any, on access to care and provider retention.[50]

3. The Department continue to study the rate adjustments needed to respond to the September 2021 NEMT audit performed by the Office of the State Auditor, with a noted evaluation of the rates needed in rural Colorado under the emerging new structure (IntelliRide serving nine Front Range counties, with transportation providers serving the remaining 55 counties in the state).

HCBS Waiver Introduction

HCBS rates and payment methodologies are notoriously hard to measure, analyze, benchmark, and compare. Each waiver typically contains a large benefit set that serves the member enrolled in that waiver. Some members use all the services available within a waiver, whereas some members may only utilize one or two services. Additionally, service definitions may vary and those with the same or similar names can be entirely different depending on the waiver. Payment rates may also vary between services on waivers.

Comparison between states is even more difficult, as each state may have different provider or worker requirements, service definitions, regulatory structures, and federal agreements. Because HCBS is almost entirely funded through Medicaid, there is not an appropriate analog among private or other public healthcare marketplaces. Finally, HCBS is typically on the lower end of the reimbursement spectrum across the country, often at or near minimum wage. Minimum wage varies from $7.25 in Virginia to almost double ($13) in California, reflecting in part differences in cost of living. Benchmarking across states is therefore difficult to establish and interpret.

Additionally, since the conclusion of the analysis of these services, the entire industry has entered a workforce crisis. The COVID-19 pandemic coupled with pre-existing factors like demographic shifts, emerging and significant competition in hiring these workers across industries, and stagnation in wage and compensation have created an unparalleled workforce crisis. Accordingly, the Department no longer can no longer accurately state these waivers are being reimbursed at a sufficient level. The Department has recognized this emergency and has many different strategies to address this crisis, including new funding for a higher base wage to help stabilize and strengthen the HCBS ecosystem to ensure Colorado's aging and disabled populations are able to receive these critical services now and into the future.

[50] The Department is currently collecting this data and will monitor for up to a minimum of 24 months, at which point the Department will evaluate the need to continue monitoring transportation data.

I. Adult HCBS Waivers

A. Summary of Findings

Analyses are inconclusive to determine if Adult HCBS waiver payments allow for member access and provider retention for the following waivers. [51,52]

- Waiver for Persons with Brain Injury (BI) payments at 98.12%-164.44% of the benchmark;
- Waiver for Persons with Developmental Disabilities (DD) payments at 72.91%-151.36% of the benchmark;
- Supported Living Services Waiver (SLS) payments at 52.82%-131.95% of the benchmark;
- Waiver for Persons with Spinal Cord Injury (SCI) payments at 81.12%-95.24% of the benchmark.
- Community Mental Health Supports Waiver (CMHS) payments at 46.65%-112.93% of the benchmark; and
- Elderly, Blind, and Disabled Waiver (EBD) payments at 79.48%-113.20% of the benchmark. [54]

The individual rate ratios for all services reviewed under Adult HCBS waivers were 35.07% -351.23% of the benchmark.[55] However, the caveats highlighted in the introduction must be considered.

Key Considerations

Stakeholder Feedback

- Transitional Living Program (TLP) services are offered by a limited number of providers since they are unable to provide the level of care necessary for the current reimbursement rate, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services.
- ACF per diem rates are much lower than other similar levels of assisted living facility-based care provided under Health First Colorado HCBS waivers (e.g., group homes).
- There are reportedly significant access issues in rural and frontier counties for ACF provided under the CMHS waiver.
- ACF service providers report that agencies are requiring financial support to ensure the viability of the direct care workforce and continuation of these home and community-based service.

[51] These benchmarks only indicate the aggregate rate comparison for each individual waiver; for more details on rate benchmarks for individual services under adult waivers, see the 2021 Medicaid Provider Rate Review Analysis Report.
[52] Since the original publication of the 2021 Medicaid Provider Rate Review Analysis Report and claims data analyses therein, there have been considerable changes to the direct care workforce for Home and Community Based Services. These changes have presented considerable and unique challenges and thus must be taken into consideration in the development of recommendations related to Home and Community Based Services. Therefore, the Department has further determined the analyses were inconclusive to determine if HCBS payments were sufficient to allow for member access and provider retention within the current landscape. In addition, the Department is implementing efforts to directly address workforce development in order to achieve definitive rate sufficiency and improve provider retention in the immediate future.

[54] The Department recognizes that current rates for services provided under CMHS and EBD waivers may not support appropriate reimbursement for high-value services. The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.
[55] See Appendix B in the 2021 Medicaid Provider Rate Review Analysis Report for a complete list of codes reviewed under the Adult HCBS waiver services grouping.

- Mental health counseling under the BI waiver has a reportedly low number of providers, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services.
- There is a reported lack of providers for Complementary & Integrative Health Services (i.e., professional therapy services including acupuncture, chiropractic, and massage therapy services) grouping on the SCI waiver.

Additional Considerations

- Colorado's HCBS Transitional Living Program (TLP) is highly specialized and reimburses based on levels of complexity; other states' Medicaid programs do not have a service that fully encompasses the totality of services provided through TLP, which limited the ability to compare TLP rates to services in other states. As a result, TLP was excluded from the rate comparison analysis published in the 2021 Medicaid Provider Rate Review Recommendation Report.
- The Department is currently investigating rate setting methodology for TLP services and is working with providers to identify opportunities for improving access to care to TLP services.
- ACF reimbursement rates received a 25% targeted rate increase (TRI), effective October 2018 as a result of the 2017 Medicaid Provider Rate Review Recommendation Report.[56]
- Due to reportedly limited provider availability for complimentary and integrative health services, the Department prioritized direct provider outreach to providers of complimentary and integrative health services[57] since 2018 to increase enrollment of SCI providers.
- The Department continues to prioritize efforts to increase provider availability for SCI services.
- A new location for complementary and integrative health services under the SCI waiver (included under professional therapy services for the purposes of this report) was opened in January of 2019, leading to an increase in both utilizers and providers of those services.
- SCI services are only available to members in the Denver Metro area.
- Recent legislation was passed to expand the SCI waiver to members statewide; the Department is aware of this legislative change.[58]
- Day treatment services were not utilized in CY 2019 and there were no providers of day treatment services for Colorado Medicaid; the cause of this is not clear and the Department is continuing to investigate whether these services are accessed under other waivers, if there is no need for these services for members enrolled on the BI waiver, if the benefit is too confusing for providers, if the service could benefit from a rate change, among other factors.

Department Recommendations

1. The Department recommends seeking authority to implement the results of a recent Transitional Living Program (TLP) rate setting project.[59]

[56] See the July 2018 Provider Bulletin for more information.
[57] Complementary and integrative health services include massage therapy, acupuncture, and chiropractic services; procedure-code level detail of services reviewed under each grouping is contained in Appendix F in the 2021 Medicaid Provider Rate Review Analysis Report.
[58] For more information, see SB21-038.
[59] The Department is currently working on this project; the Department is seeking state and federal authority to implement new TLP rate(s), with a projected implementation date of January 1, 2023. This recommendation may require further resources.

2. The Department recommends evaluation of tiered rate reimbursement development for Alternative Care Facilities (ACFs) to support higher need members in the community.[60]

Children's HCBS Waivers

Summary of Findings

Analyses are inconclusive to determine if Children's HCBS waiver payments allow for member access and provider retention for the following waivers:[61]

- Children's Extensive Support Waiver (CES) payments at 68.19%-211.19% of the benchmark;
- Children's Habilitative Residential Program Waiver (CHRP) payments at 67.97%-306.81% of the benchmark;
- Children's Home and Community Based Services Waiver (CHCBS) payments at 34.37%-143.64% of the benchmark; and

- Children with Life Limiting Illness (CLLI) waiver payments at 58.42%-286.04% of the benchmark.[62]

The individual rate ratios for Children's HCBS waiver payments were 34.37%-307.81% of the benchmark.[63] However, the caveats highlighted in the introduction must be considered.

Key Considerations

Stakeholder Feedback

- There is a reported lack of professional therapy services providers, particularly in rural and frontier counties; some feedback indicates that rates are too low for provider retention in counties where utilization is low, which creates access issues for the members who do need CLLI, CHRP, and CES services in those counties. This is particularly notable for hippotherapy service providers.
- There is a reportedly low number of respite providers available for members enrolled in the CES and CHRP waiver.

Additional Considerations

- The Butterfly Program, a provider of several CLLI services, closed in late 2018, which led to a slight decrease in utilization; however, increases in active providers during this time indicate members' access to CLLI services was not significantly impacted by this closure; the Department will continue to monitor access to these services and whether decrease in active

[60] See the APRA HCBS Funding Plan Overview for more information. Any rate changes will be implemented upon state and federal approval. This recommendation may require additional resources.
[61] These benchmarks only indicate the aggregate rate comparison for each individual waiver; for more details on rate benchmarks for individual services under children's waivers, see the 2021 Medicaid Provider Rate Review Analysis Report.
[62] The Department recognizes that current rates for services provided under CLLI waivers may not support appropriate reimbursement for high-value services. The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.
[63] See Appendix B in the 2021 Medicaid Provider Rate Review Analysis Report for a complete list of codes reviewed under the Children's HCBS waiver services grouping.

providers for palliative and supportive care services is a result of low need for these services or if an access issue may be present, if it is unique to Medicaid, and whether it is attributable to rates.
- The Department continues to prioritize efforts to increase provider availability for CLLI, CHRP, and CES services, especially rural and frontier counties (including the Front Range).
- The CLLI waiver has typically low utilization due to the nature of the population this waiver serves; low demand for services often results in lower numbers of providers rendering those services.
- Personal care services were removed from the CES waiver in 2015 and are now available to Health First Colorado members ages 0-20 through pediatric personal care services now offered as a State Plan benefit.[64]
- In January 2019, the requirement that limited eligibility and enrollment on the CHRP waiver to foster care or child welfare recipients was removed.
- There has been a significant increase in expenditures for CHCBS waiver services, driven by much higher utilization of IHSS health maintenance services; the Department is aware of this change and is continuing to monitor IHSS health maintenance utilization and pursuing further information on the causes driving this significant increase.

Department Recommendations

1. The Department recommends further increasing the CHRP foster care home rates to align with DD waiver host home rates.[65]

2. The Department recommends aligning respite service limits provided under the CHRP waiver with respite service limits under the CES waiver.[66]

3. The Department recommends adding host homes as a residential provider type for members ages 18 and under to increase facility capacity limits and provider capacity.[67]

Aggregate Waivers & Waiver Services

Summary of Findings

Analyses suggest that Aggregate HCBS Waiver payments at 97.7% of the benchmark were inconclusive to allow for member access and provider retention.[68] The individual rate ratios were 34.37%-351.23% of the benchmark.[69]

[64] Pediatric personal care services were reviewed in the 2020 Medicaid Provider Rate Review Analysis Report.
[65] This recommendation aligns with R-10 in the 2022 Governor's Budget Request; this recommendation will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023.
[66] This recommendation aligns with R-10 in the 2022 Governor's Budget Request; this recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023.
[67] This recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023. This recommendation may require additional resources.
[68] See the 2021 Medicaid Provider Rate Review Analysis Report for more information.
[69] See Appendix B in the 2021 Medicaid Provider Rate Review Analysis Report for a complete list of codes reviewed under the Children's HCBS waiver services grouping.

Key Considerations

Stakeholder Feedback

- Stakeholders note that massage therapy services under the SCI waiver are reimbursed at a lower rate than massage therapy services reimbursed under other waivers.[70]
- Stakeholders expressed desire for number of hours for which in-home respite can be provider be increased; there is currently a 6.5-hour per day maximum for in-home respite services.
- Stakeholders also indicate that the pay structure for in-home respite services incentivizes facility-based care, such as in an ACF or nursing facility.
- There are reportedly significant access issues in rural and frontier counties for adult day and respite services provided under the CMHS waiver.
- Adult day rates are reportedly too low to continue providing the current level of care to Medicaid members.
- HCBS Final Rule established new requirements that increased administrative burden on providers of adult day services, yet the rate was not changed to reflect the added time and resources to complete these requirements.[71]
- The additional procedure code for individualized day habilitation services and the addition of virtual service delivery methods are expected to increase member access to these services.
- Some providers are concerned requirements for residential habilitation due to rule changes made in 2019 regarding Individual Residential Supports and Services (IRSS) settings will impact provider retention since the current rate may not be set at an adequate rate to provide individualized supports.
- HCBS residential, personal care, and homemaker service providers report that agencies are requiring financial support to ensure the viability of the direct care workforce and continuation of these home and community-based service.
- Provider agencies of homemaker and personal care services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.
- Provider agencies of personal care services in rural areas also expressed concerns regarding the discrepancies between rural rates and Denver County rates.
- Unit limits for behavioral services are reportedly too low to provide frequency of care preferred by providers and utilizers of these services.
- Providers expressed concerns regarding current rates and the impact the minimum wage legislation pass-through will have on their ability to cover cost of service provision through Medicaid reimbursement alone.[72]

Additional Considerations

- Several reimbursement rates for SLS waiver services vary for the same or similar services provided on other waivers.[73]

[70] For detailed HCBS waivers rate information, see the Health First Colorado Fee Schedule.
[71] For more information on the HCBS Final Rule, see the HCBS Settings Final Rule web page.
[72] This feedback refers to SB19-238, which was signed into law in 2019 with a wage pass-through for IHSS personal care and homemaker services.
[73] Some rates are in alignment with DD waiver services. See the Health First Colorado Fee Schedule for more details.

- Several reimbursement rates for EBD waiver services vary for the same or similar services provided on other waivers.[74]
- Several reimbursement rates for CMHS waiver services vary for the same or similar services provided on other waivers.[75]
- In-home respite is not available on the CMHS waiver but is available on other adult waivers.
- The current state of the direct care workforce, described in Appendix H in the 2021 Medicaid Provider Rate Review Analysis Report.[76]
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which requires agencies providing personal care and homemaker services to pass an increase in rates directly through direct care workers.[77]
- Cost reporting is needed to address wages, but stakeholders thus far have been hesitant to share cost reports.
- In September 2020, an additional procedure code was added to adult day services on the BI, EBD, CMHS, and SCI waivers to provide a billable 15-minute unit.
- A new procedure code was temporarily added for day habilitation to provide one-on-one individualized service; the Department is investigating if this service should be permanently added to day habilitation services.
- The Department has started allowing reimbursement for HCBS telehealth services and is working to implement HCBS telehealth services permanently, which is expected to increase access.
- Continued efforts are being made by the Department to increase the availability of HCBS providers in the Front Range and rural areas.

Department Recommendations

1. The Department recommends prioritizing efforts to stabilize and strengthen the long-term care direct care workforce.

2. The Department recommends aligning rates for services that span multiple waivers .[78]

3. The Department recommends pursuing the implementation of geographic rate modifiers for waiver services to address disparities of provider capacity across the state.[79]

[74] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.
[75] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.
[76] For more information, see Appendix H in the 2021 Medicaid Provider Rate Review Analysis Report.
[77] For more information, see SB19-238.
[78] This will include bringing the massage rate on CLLI and SCI waivers to match the SLS rate, which aligns with R-10 in the 2022 Governor's Budget Request. The Department has identified several other services, such as Non-Medical Transportation (NMT), that span multiple waivers but are set at different rates across waivers. This recommendation may require additional resources. These rate changes will be implemented upon state and federal approval.
[79] The Department is currently working on developing an implementation project plan that will be shared with stakeholders at a future time; this will be a long-term, multi-step project and may require additional resources, in addition to CMS approval and an update to the MMIS.

4. he Department recommends further investigation of respite services, including provider capacity and retention, and access to respite services across populations.[80]

5. The Department recommends a minimum of a 10% rate increase in order to support the lowest paid direct-care workers to the following services: [81]
    - ACF per diem rate;
    - Adult day;
    - Consumer-Directed Attendant Support Services (CDASS) HMA, CDASS personal care, and CDASS homemaker;
    - Day habilitation;
    - Group Residential Support Services (GRSS);
    - Homemaker (basic and enhanced);
    - Individual Residential Support Services (IRSS);
    - In-Home Support Services (IHSS) Health Maintenance Activities (HMA), IHSS personal care, and IHSS homemaker; and
    - Personal care.

Targeted Case Management (TCM)

Summary of Findings

Analyses suggest that TCM payments at 87.84% of the benchmark were inconclusive to allow for member access and provider retention.[82] The individual rate ratios were 66.52%-102.95% of the benchmark.

Key Considerations

Stakeholder Feedback

- Benefits of conflict-free case management.
- Community Centered Boards (CCBs) report that case managers are over-loaded, turnover is high.

[80] This includes investigating the impact of overnight respite, how to increase providers, and the impact of not having in-home respite available under the CMHS waiver. The Department is currently hiring for this project and plans to have more information on the scope and desired outcomes of this research by Fall 2022.
[81] This recommendation partially aligns with R-10 in the 2022 Governor's Budget Request. These rate changes, if any, will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023. These recommended rate changes are based on the following: (a) services that are tied to the direct care workforce issues noted in Appendix H of the 2021 Medicaid Provider Rate Review Analysis Report; (b) current significant budget neutrality percent of the following services: ACF - 25.4%; Individual Residential Support Services - 58.26% to 24.48%, Group Residential Support Services (GRSS) - 40.11% to 10.81%; personal care (EBD, CMHS, BI, SCI) - 24.62%; personal care (SLS) - 17.66%; homemaker (EBD,CMHS, SCI and basic homemaker for SLS) - 4.91%; enhanced homemaker (SLS) - -2.78%; (c) adult day and day habilitation services identified by stakeholder feedback and confirmed in rates and access to care analyses. Any further rate changes will be implemented upon state and federal approval.
[82] See the 2021 Medicaid Provider Rate Review Analysis Report for more information.

Additional Considerations

- The Department is dedicated to complying by federal and state regulations regarding conflict-free case management; more information is located on the Conflict-Free Case Management web page.[83]
- The Department is aware of the issues related to retention of case managers and is committed to addressing this as a priority initiative of the Case Management Redesign project.[84]

Department Recommendations

1. The Department recommends continuing support to the Case Management Redesign project/team to ensure the project/team considers all stakeholder perspectives, as well as evidence-based data that can be used to inform project initiatives.[85]

[83] This project has a projected completion date of 2024.
[84] For more information, see the Case Management Redesign web page.
[85] For more information, see the Case Management Redesign web page.