COLORADO
Department of Health Care Policy & Financing

Minutes of the Medicaid Provider Rate Review Quarterly Public Meeting

Virtual meeting:

July 18, 2025, from 9:00 a.m. – 2:00 p.m.

A recording of the 7/18 meeting is available at this link
A recording of the 7/25 meeting is available at this link

PLEASE NOTE – due to technical difficulties the recording of the 7/18/2025 meeting is not complete. The discussion cuts out halfway through TCM Case Management, and TCM Transition Coordination and Vision Services are not captured. Please refer to the notes below for these topics. We apologize for this inconvenience.

Meeting Part #1: July 18, 2025
Meeting Materials

Agenda

Presentation

Appendix A: Access to Care Summaries

Appendix B: Benchmark Ratio by Code

Appendix D: Benchmark State Selection Rationale

Appendix E: Duplicate Code List

Appendix G: Optumas Justification of Dialysis Medicare Repriced Methodology

1. Call to Order and Welcome

Megan Adamson, MPRRAC Chair, called the meeting to order at 9:02a.m. 5 of the 7 members were present and participating remotely.

A. Members on Zoom/Phone

Megan Adamson, MD, family physician from Lafayette Colorado (Chair)
Ian Goldstein, MD, MPH, CEO of Soar Autism Center (Vice Chair)
Terri Walter, MSN, RN, HopeWest, Hospice & Palliative Care
Vennita Jenkins, MBA, CEO Senior Housing Options, Inc.
Christopher Maestas, GM, AMI-Wellness Home Health
Unable to attend:
Kate Leslie, LCSW, Medicaid Mental Health provider
Tim Diesnt, CEO, Ute Pass Regional Health Service District

B. Department Staff Participants and Facilitators

HCPF: Michelle LaPlante, Kevin Martin, Lingling Nie, Hannah Hyland, Wei Deng, Siyu Zhang, David McFarland-Porter, Alaina Kelley, Alex Weichselbaum, Amanda Villalobos, Chris Lane, Devinne, Gina Robinson, Greta Moser, Melanie Reece, Sahara Karki, Tyler Collinson,
Facilitators: Brian Pool and Kate Newberg from Government Performance Solutions, Inc. (GPS)

C. Other Participants

78 total participants were present at 9:20.

2. Meeting Minutes

Motion: Christopher Maestas motioned to approve the March 21, 2025, meeting minutes. Seconded by Terri Walter.
Vote: Unanimous approval

3. Meeting Overview

Michelle LaPlante, Dylan Marcy, Brian Pool (GPS) overview of (slides 3-12)
The Agenda, Housekeeping, Disclaimer, MPRRAC/Department Roles, Rules of Governance, Out of Scope for the MPRRAC, Rules of Governance.
March 21 Meeting Minutes Approved by MPRRAC (see #2 above for details)
Meeting Structure, Meeting Purpose, Analysis Updates since March 21, 2025

4. 2025 Services Analyses

Lingling Nie reviewed Year 3 Services (2025), Regrouping Updates 1-3, (slides 13-18)
No questions or comments
Lingling Nie reviewed Duplicate Code Ranking Hierarchy Updated and Additional New Analysis Summary Since March Meeting, and Recommendation Method Reminder (slides 19 – 23)
No questions or comments
Hannah Hyland reviewed Colorado Medicaid Provider Tarriff Impact Survey (slides 24 – 25)
C: A future survey (e.g., next year) could be helpful in the future as inflation and tariffs change.
Q: Any plans to do a follow-up survey? Answer: The Department will look at resources available for next year. The Department will bring this conversation up in November to discuss next year's cycle and survey timing.
Q: Was 10,000 surveys sent out? Answer: Yes, 10,000 to Medicaid Provider types signed up for the newsletter; and the Department received 103 responses.
Kevin Martin from the Department noted that meeting attendees using AI to transcribe their notes to be aware those sometimes make mistakes, so please refer to the Department for the official notes.

Brian Pool facilitated a discussion of 2025 Service Analyses of the following:

1. **Dialysis and Dialysis-Related Services (slides 28 – 34)**

Dialysis Facility

- **Presentation Notes:** Brian Pool reviewed Dialysis & Dialysis-related Services Facility Recap (slide 28), Kimberly Preston reviewed "New HFC Composite Pricing" (slide 29); lab work, dialysis, materials, etc. are all wrapped into the single rate and the rate is determined by where the facility is located. Codes 841 & 851 (in-home dialysis) have separate rates when billed with condition code 74. Code 74 is a reference code to trigger for the different rate. Brian Pool reviewed benchmark ratio by rate area, top 10 rates by utilization, and

access to care summary recap slides (30 – 32); Kimberly Preston reviewed Medicare Repricing Methodology (slide 33) some factors, such as BMI, were not included because the data is not available. Kimberly Preston reviewed New Stakeholder Data Benchmark Comparison (slide 34) of MPRRAC and DaVita. Both start with Medicare base rate and use the same wage-adjusted rate but the difference in PPS Adjustment Factors and the difference is due to assumptions. The Department uses diagnosis codes, member's age, and location (e.g., Colorado Springs) and DaVita uses CMS national average data. See Appendix G for more information.

- **Public Comment:** No public comment.
- **MPRRAC Discussion:** Terri & Megan said the extra information is very helpful and acknowledged the regional/location differences are something to be considered in discussions.
  Ian said prioritizing regions that are under 80% and trying to bring up to 80% (e.g., rural Colorado). MPRRAC members agree.
  Ian noted 80% reference is related to Medicare.
- Motion by Megan A.: "Move those rates/areas that are under 80% to 80%", Vennita J. Seconded. Unanimously passed.

1.2 Dialysis Non-Facility

- **Presentation Notes:** Brian Pool reviewed critical benchmark ranges, top 10 codes by utilization, and access to care (slides 37-40).
- **Public Comment:** No public comment.
- **MPRRAC Discussion:** Terri it does not seem like any changes are needed. Christopher agreed.
- **Motion by Ian G.:** "Increase those codes that are less than 80% up to 80% and leave remaining codes unchanged." Chris M. Seconded. Unanimously passed.

2. DIDD Dental Services

- **Presentation Notes**: Brian Pool reviewed (slides 44 – 54), DIDD services, preventive code analysis summary, ADA rate comparison analysis summary;
  Other states' benchmark analysis summary – these are the 100 codes that have ADA in other states and used 5 states who have enhanced or increased coverage for DIDD, noting none are below 100% compared to other states (see Appendix B for additional details);
  Top 10 codes by utilization, DIDD ADA benchmark outlier bubble charts, access to care summary, Compared to Colorado Medicaid Dental – New, MPRRAC recommendations.
- **Public Comment:** 2 Public Comments: Kevin Patterson, DDS and Past President of Colorado Dental Association (10:07-10:09 AM); Jeff Lodl, DDS and President Elect to Colorado Dental Association (10:09-10:11) and comment from Chat at 10:26 AM: Lauren from Colorado Dental Association: From CDA, I just wanted to note that we recommend looking at the utilization percentage of a rate in conjunction with the DIDD rate amount, to see which rates that are most highly utilized are also in need of an increase, to prioritize those rates, particularly when budget may be challenging to get any increases to rates.
- **MPRRAC Discussion:** Ian: Do we know how much higher the rates are for the 322 codes? Answer: Wei Deng – provided answer at 10:12 AM; benchmark range is DIDD rates higher than the Medicaid State plan, is 100-761%, for those lower, it is between 56-99.8%. Megan said it is difficult to know which benchmark to use because ADA and Benchmark states seem very different. Ian said it is an important service to provide the DIDD population, but it is challenging to get to a recommendation because of the benchmarks. The five benchmark states potentially have the risk of being less well reimbursed states. ADA is private paid rates. Doesn't like either rate. Agree DIDD should be at a premium to standard dental rates given the increased patient complexity and the provider cost. Lingling Nie: Medicare does not cover dental benefits, so used other states' as the benchmark in 2018. In 2023, based on CDA feedback, ADA 2020 rate is used as the

benchmark. ADA is an average of national commercial rates. Neither is a perfect benchmark. There is an equity issue: if we only use ADA for dental, seems not fair to other services; But ADA does have a national average, not like other services. Megan: is there a typical difference between the DIDD rates and the standard dental rate? Answer: Lingling Nie, 2023 review, we gave recommendation to 20 core preventive code for regular dental, big push, that cause the lag between Medicaid and DIDD rate. Terri: should DIDD be compared to adult Medicaid rates? Lingling Nie: DIDD should be higher because of the uniqueness of the population, but you make the decision. Vennita suggested adjusting the 22 codes that are lower to a higher rate. Megan: should the DIDD dental codes always be a X percentage higher than regular dental code rates? Ian suggested adding some premium to the standard dental rates for DIDD population. Would like to see a code level comparison at the August meeting. Wei Deng: for those higher rates, an average of 179% and those that are lower are 84% of Medicaid. Christopher asked how did the DIDD population end up with some codes lower than the standard dental rates? Answer: Lingling Nie said the DIDD rates have not been reviewed in the past 10 years. Christopher recommended that the Department include DIDD rates with standard rate reviews. Kevin Martin noted that the process is now and going forward. Wei: 35.47% on slide 44 is the DIDD dental providers increase.

Data Request for August: List codes that are the highest utilized for DIDD dental and compare to the standard dental rate for those codes (current rates, percentage of rate columns)

Motion by Megan A. "For the 22 DIDD dental codes that are less than 100% of the Medicaid standard dental increase the DIDD rate to 150% of the Colorado Medicaid Dental Rate." Christopher seconded. Unanimously passed.

Christopher M. asked if there is a Denver-specific reimbursement for some rates and has that been considered or part of this discussion? Lingling Nie, we have a cost adjustment between states and within Colorado there is a Denver metro area vs. non-Denver but that is only for some rates, not all.

3. **Durable Medical Equipment (DME)**
   - **Presentation Notes:** Brian Pool reviewed slides 56 – 65), DME recap, critical benchmark ranges, top 10 codes by utilization, above 140% outlier bubble chart, below 60% outlier bubble chart, access to care summary, repair code K0739 New – critical code above 100% of benchmark, New – Upper Payment Limit (UPL), and MPRRAC recommendations.
   - **Public Comment:** 5 Public Comments; Paul Hogfeldt, President of Colorado Association for Medical Equipment Services (CAMES) (10:41 – 10:43 AM); Kelli Ore, representing CAMES (10:43-10:46 AM); Karlene Martin read a statement from the CEO & President of Craig Hospital (10:46 – 10:48 AM); Jim, Chair of the Independence Center in Colorado Springs (10:48 – 10:50 AM); Lindsey Gummer, MD, Children's Hospital Colorado (10:51 – 10:53 AM)

     Kimberly Preston noted that some of the public comments fall under prosthetics, orthotics, and disposable supplies.

     Posted in Chat at 10:58 AM: To compliment Dr. Gumer's testimony and to respond to Dr Adamson's question, Children's submitted a letter with the following DME code recommendations: DME supplies for children and youth with complex care needs are keeping them safely at home and preventing short- and long-term costs associated with more frequent hospital visits, exacerbation of conditions, or unnecessary inpatient stays. Please maintain rates that are currently above the benchmark and raise the rest of these rates to at least 90% of benchmark: A4220-2, A4230-1, E0779-80, 82-83, E0791, J1642, and K0455.
   - **MPRRAC Discussion:** Megan thanked the stakeholders for their feedback and asked if they can send a list of specific codes they want MPRRAC to review.

     Ian low Medicaid provider ratio and public stakeholder comments that the 91% benchmark

of Medicare now seems low.
Megan I would support moving the codes with rates below 80% to 80% and leave the codes that are above 100% where they are because the rationale supports those rates.
Motion by Megan A. Adjust codes with rates below 80% to 80%. Ian seconded. Unanimously supported
Motion by Ian G. For the codes without benchmarks, move all codes below 80% to 80%.
Motion by Megan A. For FFS codes without benchmarks, adjust for inflation by 3%. Seconded by Ian. Unanimously passed.

4. **Prosthetics, Orthotics and Disposable Supplies (POS)**

4.1 Prosthetics:

- **Presentation Notes:** Brian Pool reviewed slides 67 – 73); POS UPL New, Prosthetics recap, Prosthetics Update critical benchmark ranges, top 10 codes by utilization, access to care summary, and MPRRAC recommendations.
- **Public Comment:** No public comments. Maggie Baumer from Hanger Clinic at 11:07 AM asked a question about the 29% Medicaid providers on slide 71. Clarification from Department this is the percent of Medicaid providers serving this population. Maggie asked a follow-up question if this is similar to other services. The Department suggested looking at the Access to Care Appendix.
- **MPRRAC Discussion:** Ian G. suggested applying the same methodology here a above – raise codes that are below 80% to 80%. Megan it would be good to understand the fiscal impact. Ian noted that the total expenditures are relatively low, so the fiscal impact will likely be small.
  Motion by Megan increase the codes that are below 80% to 80%. Terri seconded. Unanimously passed.

4.2 Orthotics:

- **Presentation Notes:** Brian Pool reviewed slides 74 – 82; POS orthotics recap, orthotics update critical benchmark ranges, top 10 codes by utilization, outlier bubble chart, access to care summary, stakeholder engagement update – New, critical codes above 100% benchmark – New, and MPRRAC recommendations.
- **Public Comment:** 9 public comments. Kristen Thessing from Cranial Kids, (11:16 – 11:18 AM); Justin Bova (11:18 -11:20 AM); Emma DiMarco, Occupational Therapist (11:20 – 11:22 AM); Anna Pablo from Cranial Kids (11:23 – 11:25 AM); Heather Willets Prosthetist-Orthotist (11:25 – 11:27 AM) Maggie Baumer from Hanger Clinic (11:27 – 11:28 AM); Jason Oldejans, Prosthetist-Orthotist (11:28 – 11:30 AM); Tim Littlefield, biomedical engineer for Cranial Technologies (11:31 – 11:33 AM); Wendy Bourquin, Physical Therapist and Orthotist (11:34 – 11:36 AM).
- **MPRRAC Discussion:** Ian thanked the stakeholders for their details and specificity.
  Motion by Megan suggested increase codes below 80% to 80% and keep rates above that unchanged. Ian seconded. Unanimously approved.
  Motion by Ian, inflation adjustment for codes without a benchmark. Terri seconded. Unanimously approved.
  Break for lunch at 11:39 for 21 minutes.
  68 participants at 12:05 PM

4.3 Enteral Formula (New):

- **Presentation Notes:** Brian Pool reviewed slides 83 – 92. POS enteral formula, critical benchmark ranges, top 10 codes by utilization, outliers above 140%, outliers below 60%, codes above 100% of the benchmark, access to care summary, and MPRRAC recommendations. These are not pharmacy rates, these are what are administered in a physician office and coded as DME. The pharmacy rates are changed weekly.

- **Public Comment:** 3 public comments. Heather Ricketts from Sentido Health (12:09 – 12:11 PM), Paige Trahan from Sentido Health (12:12 – 12:15 PM), and Jim Melancon from Aveanna Healthcare (12:15 – 12:18 PM). From chat at 12:18 PM: From Elizabeth Freudental from CHCO: Hi there, in the Children's letter, we tried to group codes associated with parenteral nutrition, both DME and POS, as well as a few target in-home infusion supplies in that list of codes. Thank you for your care in sorting them to the appropriate categories for your discussion!
- **MPRRAC Discussion:** Ian even though above the Medicare benchmark it is for reasons of populations served. Megan, we heard good rationale for keeping the rates unchanged. **Motion by Megan**, "Keep the rates unchanged." Ian seconded. Unanimously passed.

4.4 Other and Disposable Supplies

- **Presentation Notes:** Brian Pool reviewed slides 93 – 100. Update, critical benchmark ranges, top 10 codes by utilization, 140% above outlier, 60% below outlier, access to care summary, and MPRRAC recommendations.
- **Public Comment:** No public comment.
- **MPRRAC Discussion:** Megan raised differences between syringes in the outliers. **Motion by Ian,** "Raise those codes that are below 80% to 80% and leave other codes unchanged. Terri seconded. Unanimously passed.
  Motion by Ian, "Raise the FFS codes without benchmarks by 3% to adjust for inflation." Terri seconded. Unanimously passed.

5. Laboratory and Pathology Services

- **Presentation Notes:** Brian Pool reviewed slides 102 – 109. Update, critical benchmark ranges, top 10 codes by utilization, outlier chart, access to care summary, UPL methodology for codes above 100% of the benchmark – New, and MPRRAC recommendations
- **Public Comment:** 2 public comments. Patrick Long, Clinical practicing medical geneticist (12:29 – 12:31 PM); Whitney Glover represents GeneDx (12:32 – 12:34);
  From Q&A at 12:35 PM by alal: Could you please let me know to the medical policy which Medicaid CO refer for prenatal genetic testing, NIPT and Cancer testing?
- **MPRRAC Discussion:** Ian asked to clarify the UPL. Answer: 30 of the 71 codes are subject to UPL and cannot go above 100% of Medicare.
  Motion by Megan, Add the two codes (81415 and 81416) that are not Ian seconded. Unanimously passed.
- **Motion by Ian,** "For any valid FFS codes without benchmarks, do the 3% increase to adjust for inflation." Unanimously passed.

6. Outpatient PT/OT/ST

6.1 Physical Therapy

- **Presentation Notes:** Brian Pool reviewed slides 111 – 119. Outpatient PT recap, benchmark analysis summary, top 10 codes by utilization, access to care summary, year-over-year reimbursement rate trend analysis – New, preventive care in outpatient PT – New, potential preventive care in outpatient PT – New, and MPRRAC recommendations.
- **Public Comment:** 1 public comment. Ellen Jensby from Alliance representing early intervention brokers and providers (12:45 – 12:47 PM).
- **MPRRAC Discussion:** Ian, is this PT for all members, children through adults? Is there a way to adapt reimbursement for the setting or is it just 1 rate? Answer: it includes everyone in outpatient setting. Early Intervention (EI) does encompass PT/OT and EI will be in a separate discussion. Chris, why is the call out for preventive codes? Answer: provider community wanted primary care preventive codes called out so for parity we have done that here. CMS has a website for all preventive codes. Megan, we have many codes close the 100% of the benchmark, so I am comfortable where these codes are and suggesting keeping these codes the same. Terri, is 97530 reimbursement the same regardless of the credential of the person providing the service? Answer: Physical therapy assistants, occupational therapy

assistants, and speech language pathology clinical fellows are authorized to provide services within their scope of practice, and under the General Supervision of an enrolled provider who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules.

Motion by Ian, "Bring the codes 97530 & 97533 to 100%." Chris seconded. Unanimously passed.

Motion by Megan "For FFS codes without benchmark increase the rate by 3% to adjust for inflation." Ian seconded. Unanimously passed.

6.2 Occupational Therapy

- **Presentation Notes:** Brian Pool reviewed slides 120 – 126. Outpatient OT recap, benchmark analysis summary, top 10 codes by utilization, access to care summary, potential preventive care in outpatient OT – New, and MPRRAC recommendations.
- **Public Comment:**
- **MPRRAC Discussion:** Ian, these are similar to the PT so suggest matching what we did for PT.

  Motion by Ian, "Bring the codes 97530 & 97533 to 100%." Chris seconded. Unanimously passed.

  Motion by Ian "For FFS codes without benchmark increase the rate by 3% to adjust for inflation." Chris seconded. Unanimously passed.

6.3 Speech Therapy

- **Presentation Notes:** Brian Pool reviewed slides 127 – 135. Outpatient ST recap, benchmark analysis summary, top 10 codes by utilization, outlier bubble chart, access to care summary, Rate alignment issues – New, potential preventive care in outpatient ST – New, and MPRRAC recommendations.
- **Public Comment:** 2 public comments. Ellen Jensby with Alliance (1 :05 – 1 :07 PM); Jessi Hogan from Aspen Speech Therapy (1:08 – 1:09 PM)
- **MPRRAC Discussion:** Ian said the comparison to home health in the slides is interesting and it seems odd that ST is not structured the same as OT/PT but realize that is out of scope to address parity but I think the Department should look into this. The four codes should be brought up to 100%. The 92507+GT should be brought down to 100% because it is telehealth services. Megan, I support looking at the four codes Ian named and bringing the code with the GT modifier down to 100%. Terri noted that home health has additional expense of drive time to and from so it makes sense that is a higher rate. Terri, the GT modifier should not change the rate.

  Policy Recommendations by Ian, 1) Evaluate the data of 92507 and other codes ST to OT/PT and home health for fairness, acknowledging home health rates account for drive time to and from.

  2) Look at the rate structure by unit (e.g., PT/OT allowable to bill in 15-minute increments and ST can only bill for a single unit, so if spend 3 hours with a patient PT/OT is reimbursed more than ST) between ST, PT/OT to ensure parity.

  Motion by Ian, "Bring the codes 92507, 92609, 92508 and 92526 to 100%, and bring down the *92507 with GT modifier* down to 100% or said another way, no premium for the GT modifier." Megan seconded. Unanimously passed.

7. Specialty Care Services:

- **Presentation Notes:** Brian Pool reviewed slides 137 – 141. Update, skin substitute groups by utilization, access to care summary, and MPRRAC recommendations.
- **Public Comment:** No public comment. The individuals that signed up were not in the meeting.
- **MPRRAC Discussion:** Terri referenced a letter for reimbursement for non-human skin grafts, but it is one of the codes below 80%. Kimberly Preston, these are reimbursed per sq centimeter.

Motion by Ian, "Raise those codes that are below 80% to 80% and leave other codes unchanged. Vennita seconded. Unanimously passed.

8. **Early Intervention TCM Services:**
   - **Presentation Notes:** Brian Pool reviewed slides 143 – 146. EI TCM update, access to care summary, and MPRRAC recommendations.
   - **Public Comment:** 1 public comment**.** Ellen Jensby from Alliance (1:33 – 1:34 PM).
   - **MPRRAC Discussion:** Megan asked, is it just two codes in this category? Answer: Yes. Is 1017 a unit code? Answer: it is a 15-minute unit code. From chat at 2:01 PM: message is from our EI policy specialists regarding therapy services:
     Just FYI for the recommendation for the Dept. to look at parity in rates. Someone brought up that Home Health rates include travel and mileage and Outpatient doesn't include that because it is clinic-based. EI PT, OT, ST providers provide services in the family's home and do not get reimbursed for travel and mileage, so it would be parity to compare with Home Health rates.
     Motion by Vennita, "Raise T1017 TL to 80% of the benchmark." Ian seconded. Unanimously passed.
9. **Targeted Case Management (TCM):**
   - **Presentation Notes:** Brian Pool reviewed slides 148 – 156. TCM Recap, code list – New, access to care summary, transition coordination services (TCS), TCS access to care summary, and MPRRAC recommendations.
   - **Public Comment:** 1 public comment: Ellen Jensby from Alliance (1:39 – 1:41 PM).
   - **MPRRAC Discussion:** Megan asked, since there is not a benchmark for comparison, what is the difference between in person and telehealth and how is it different from the TCM monthly code? Answer: TCM monthly code covers things not covered by the other rates. Terri asked, is TCM like a per member per month? Answer: Yes, it is similar but they have to conduct an activity, it is not a payment for every member they serve whether or not they provide service in a given month. Also, Colorado splits out the monitoring where other states do not. Ryann Lubitz from HCPF, clarified that it is 1 per month, and that monitoring requires 1 of 4 visits must be in person whereas the other 3 can be by telehealth. There is also a separate contracted payment structure that is separate from the rates so billable rates are not the only way TCM agencies are paid. Relied on provider community and policy experts to find states with a similar structure but Colorado does have a unique TCM structure. See appendix C.4 for more details on the benchmark.
     Motion by Vennita, "raise the TCM monthly to 100% of the benchmark." Terri seconded. Unamiously passed.
     Motion by Megan, "For codes without benchmark increase the rate by 3% to adjust for inflation." Ian seconded. Unanimously passed.
10. **Transition Coordination Services (from non-congregate to a community setting).**
    - **Motion by Ian**, "Leave the transition coordination services rates unchanged". Chris seconded. Unanimously agreed.
11. **Vision Services**
    - **Presentation Notes:** Reviewed slides 158 – 167. Vision services – New, benchmark analysis summary, top 10 codes by utilization, outlier bubble chart, access to care summary, preventive care in vision services, added NM to benchmark state list per provider's request, and MPRRAC recommendations.
    - **Public Comment:** No public comment.
    - **MPRRAC Discussion:** From Dept. this is not the same vision category you saw back in March, this is a regrouping. Terri noted there is no utilization for some of the codes.
      Motion by Megan, "increase the codes that are below 80% to 80%, and codes without a benchmark do the 3% increase to adjust for inflation." Vennita seconded. Unanimously passed.

The remaining topics will be covered at the July 25, 2025 meeting.

5. Next Steps and Announcements

Next Meeting on Friday, July, 25, 2025 from 9AM-2PM.

Contact information was also shared (see below):

Website https://hcpf.colorado.gov/rate-review-public-meetings

Lingling Nie
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Best email for rate review is HCPF_RateReview@state.co.us

6. Meeting Adjourned at 2:32PM

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Minutes of the Medicaid Provider Rate Review Quarterly Public Meeting

Virtual meeting:

July 25, 2025, from 9:00 a.m. – 2:00 p.m.

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1. Call to Order and Welcome

Megan Adamson, MPRRAC Chair, called the meeting to order at 9:02a.m. 6 of the 7 members were present and participating remotely.

A. Members on Zoom/Phone

Megan Adamson, MD, family physician from Lafayette Colorado (Chair)
Ian Goldstein, MD, MPH, CEO of Soar Autism Center (Vice Chair)
Terri Walter, MSN, RN, HopeWest, Hospice & Palliative Care
Kate Leslie, LCSW, Medicaid Mental Health provider (joined at 9:55AM)
Christopher Maestas, GM, AMI-Wellness Home Health
Tim Diesnt, CEO, Ute Pass Regional Health Service District
Unable to attend:
Vennita Jenkins, MBA, CEO Senior Housing Options, Inc.

B. Department Staff Participants and Facilitators

HCPF: Michelle LaPlante, Kevin Martin, Hannah Hyland, Wei Deng, Siyu Zhang, David McFarland-Porter, Kevin Anderson, Melanie Reese, Christina Winship.
Facilitators: Brian Pool and Agustín Leone from Government Performance Solutions, Inc. (GPS)

C. Other Participants

35 total participants were present at 9:15.

2. 2025 Services Analyses Continued

12. Physician Services (18 service subcategories)

12.1 Allergy and Immunology

- **Presentation Notes:** Brian Pool (GPS) presented slides 168–176, covering a range of data related to Allergy and Immunology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment was received for this service category.
- **MPRRAC Discussion:** Ian Goldstein proposed using the same methodology as previous services—raising codes below 80% of benchmark to the 80% level.
  - Terri Walter seconded the motion.

- No objections were raised, and the committee unanimously agreed to proceed with the recommendation.

- **MPRRAC Recommendation:** Raise reimbursement rates for codes currently below 80% of benchmark to the 80% level.

12.2 Cardiology

- **Presentation Notes:** Brian Pool reviewed slides 178-184; covering a range of data related to Cardiology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment was received for this service category.
- **MPRRAC Discussion:** Ian Goldstein proposed a three-part recommendation: Raise all codes currently below 80% of benchmark to the 80% level, apply a 3% inflation adjustment to codes that do not have a benchmark comparison and lower any code that exceeds 140% of benchmark to 100%—but only if it was benchmarked to Medicare.
- Megan Adamson voiced concern over outliers on the high end and supported this tiered approach, especially given changes in Medicare rates over time.
- Wei Deng agreed to look into the specific codes above 140%.
- Christopher Maestas flagged CPT 93740 (temperature gradient studies), which appeared to be ~600% of benchmark, but Ian noted it was benchmarked to other states (not Medicare). The group agreed to leave it unchanged due to the low payment amount and non-Medicare benchmark.
- **MPRRAC Recommendation:** Raise reimbursement rates for codes currently below 80% of benchmark to the 80% level.
  - Apply a 3% inflation increase for codes without benchmark comparisons.
  - Lower codes exceeding 140% of benchmark down to 100% only if they are benchmarked to Medicare.
  - Leave codes above 140% that are benchmarked to other state Medicaid rates unchanged.
  - The recommendation was unanimously approved.

12.3 Dermatology

- **Presentation Notes:** Brian Pool reviewed slides 184-191; covering a range of data related to Dermatology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment was received for this service category.
- **MPRRAC Discussion:** Megan Adamson proposed bringing all codes below 80% of benchmark up to 80%, noting that all codes were benchmarked to Medicare.
- Terri Walter raised the question of whether codes with no utilization should be included.
- Kim Preston (HCPF) clarified that codes with no utilization still have benchmark data and were reviewed. The lack of FY24 utilization does not mean they won't be used in the future.
- The Committee aligned that even low- or zero-utilization codes should be adjusted for sustainability.
- **MPRRAC Recommendation:** Raise all codes currently below 80% of benchmark to 80%, including those with no utilization in FY24.
  - The recommendation was unanimously approved.

12.4 ED and Hospital Evaluation and Management

- **Presentation Notes:** Brian Pool reviewed slides 192-199; covering a range of data related to ED and Hospital Evaluation and Management services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment
- **MPRRAC Discussion:** Megan Adamson initiated the discussion, recommending a consistent approach: Increase all codes below 80% of benchmark up to 80%, apply a 3%

inflation adjustment to codes without a benchmark, no change to codes within 80–100% or other ranges.
- Terri Walter and Ian Goldstein voiced agreement.
- Christopher Maestas noted it would be important to monitor future Medicare reimbursement trends, particularly for facility-based care.
- No objections were raised to the proposed approach.
- **MPRRAC Recommendation:** Raise all codes below 80% of benchmark to 80%
  - Apply a 3% inflation adjustment to codes without a benchmark
  - The recommendation was unanimously approved.

12.5 Ear, Nose and Throat (ENT)
- **Presentation Notes:** Brian Pool reviewed slides 200-206; covering a range of data related to ENT services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment was received for this service category.
- **MPRRAC Discussion:** Megan Adamson and Ian Goldstein recommended the standard adjustment approach: Raise all codes below 80% of benchmark to 80%, apply a 3% inflation adjustment to codes without a benchmark, lower any code above 140% of benchmark (if benchmarked to Medicare) to 100%.
- The Committee noted one code at above 800% of benchmark, which had no utilization and was benchmarked to Medicare. Wei Deng confirmed this.
- Members acknowledged that most codes above 140% had no utilization, but supported evaluating those benchmarked to other states as needed.
- **MPRRAC Recommendation:** Raise all codes below 80% of benchmark to 80%
  - Lower codes above 140% (if benchmarked to Medicare) to 100%
  - Apply a 3% inflation adjustment to codes without a benchmark
  - Refer extreme outliers benchmarked to other states for further department review
  - The recommendation was unanimously approved.

12.6 Family Planning
- **Presentation Notes:** Brian Pool reviewed slides 207-213; covering a range of data related to Family Planning services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment (1):** A pediatric resident at Children's Hospital Colorado and member of the Colorado Chapter of the American Academy of Pediatrics, shared the following:
  - Emphasized the importance of access to adolescent contraceptive care through Medicaid and Title X-funded clinics
  - Advocated for maintaining high reimbursement rates for long-acting reversible contraceptives (LARCs), particularly implant insertion code 11981–11983, to preserve access
  - Recommended increasing reimbursement for IUD insertion code 58300 due to its complexity and importance
  - Cited a 50% drop in teen pregnancy following improved LARC access in Colorado
- **MPRRAC Discussion:** Megan Adamson, noted that high rates for some LARC codes were justified given their clinical value and cost structure
- IUD insertion code 58300 was discussed as being under-reimbursed (72% of benchmark); suggested it be brought up to 100% of benchmark
- Terri Walter supported maintaining codes 11981, 11982, and 11983 at current rates due to their proven value
- Ian Goldstein agreed and proposed bringing 58300 to 100% while leaving the long-standing implant codes untouched
- Additional recommendation: raise any remaining codes below 80% of benchmark to 80%
- **MPRRAC Recommendation:**

- Raise all codes below 80% of benchmark to 80%
- Increase code 58300 (IUD insertion) to 100% of benchmark
- Maintain current rates for codes 11981, 11982, and 11983
- The recommendation passed with full support.

12.7 Gastroenterology

- **Presentation Notes:** Brian Pool reviewed slides 214-220; covering a range of data related to Gastroenterology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations. Megan Adamson clarified that most of these are surgical procedures.
- **Public Comment:** No public comments were submitted.
- **MPRRAC Discussion:** Centered on bringing all codes below 80% up to 80% of benchmark and applying a 3% inflationary increase for codes without a benchmark
- **MPRRAC Recommendation:**
  - Raise all codes below 80% to 80% of benchmark
  - Apply a 3% inflation adjustment to codes without a benchmark
  - Recommendation passed with full support.

12.8 Gynecology

- **Presentation Notes:** Brian Pool reviewed slides 221-227; covering a range of data related to Gynecology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** None submitted
- **MPRRAC Discussion:** Terri Walter asked whether these surgical codes would be reviewed again next year
- Melanie Reese (HCPF) confirmed that additional surgery codes are planned for inclusion in the next review cycle
- Terri Walter proposed bringing all codes below 80% up to 80% of benchmark and applying a 3% inflationary increase for codes without a benchmark
- **MPRRAC Recommendation:**
  - Bring codes below 80% up to 80% of benchmark
  - Apply 3% inflation adjustment for non-benchmarked codes
  - Recommendation passed with full support.

12.9 Health Education

- **Presentation Notes:** Brian Pool reviewed slides 228-235; covering a range of data related to Health Education services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** None submitted
- **MPRRAC Discussion:** Wei Deng Clarified code transition from 96040 to 96041
- 96041 benchmarked using prior code's rates, resulting in ~102% benchmark
- Proposal: Leave current rates as-is and applying a 3% inflationary adjustment for codes without a benchmark
- **MPRRAC Recommendation:**
  - Maintain current reimbursement rates
  - Apply 3% inflationary increase to codes without an external benchmark
  - Recommendation unanimously passed.

12.10 Medication Injections and Infusions

- **Presentation Notes:** Brian Pool reviewed slides 236-244; covering a range of data related to injections and infusions, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations. Megan Adamson noted the primary outliers included a knee injection for arthritis and a nebulizer treatment, both with extreme benchmark differentials.
- **Public Comment:** No public comment was submitted for this service category

- **MPRRAC Discussion:** Megan Adamson proposed the knee injection code (J7325) is be reduced to 100%.
- David Macfarland Porter (HCPF) confirmed J7325 is benchmarked to Medicare
- Additional discussion proposed a standard approach: Raise codes below 80% up to 80%, reduce codes above 140% and benchmarked to Medicare down to 100%, apply a 3% inflationary increase to codes without a benchmark
- **MPRRAC Recommendation:**
  - Increase any codes below 80% to 80%
  - Reduce codes above 140% (if benchmarked to Medicare) to 100%
  - Apply a 3% inflationary increase to codes without a benchmark
  - Recommendation unanimously passed.

12.11 Neuro/Psychological Testing Services

- **Presentation Notes:** Brian Pool reviewed slides 245-254; covering a range of data related to neuro/psychological testing services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations. Brian flagged an important asterisk on slide 252 referencing the separation of Task Force A and B, indicating a bifurcated approach to different subsets of services or populations. During the presentation, both Megan Adamson and Kate Leslie clarified that an outlier code under discussion is one typically administered by a behavioral health technician, not a licensed psychologist or physician.
- **Public Comment:** Four public commenters provided perspectives emphasizing access and payment inadequacies.
  - A Clinical Psychologist highlighted a 1–2 year waitlist for children needing neuropsych testing, especially those who are neurodivergent.
    1. Pointed out confusion in mixing physician and clinical psychologist services in code groupings.
    2. Stated an inability to access key codes: 96217, 96110, 96113.
    3. Emphasized inadequate Medicaid provider availability—fewer than 100 individuals statewide.
    4. Stressed that early intervention (ages 2–6) yields the best outcomes and that the waitlist is a major barrier.
    5. Urged the committee to read the submitted letters for a fuller picture.
  - A Pediatrician at Peak Pediatrics, warned that payment reductions put pediatric patients at risk, given their unique needs.
    1. Advocated for enhancing the benchmark ratios for 96110, 96127, G8431, and G8510.
    2. Supported the view that neuropsych provider shortages are real, and the waitlist concerns are not exaggerated.
  - A Neuropsychologist at Children's Hospital Colorado, called for raising rates on six codes: 96116, 96121, 96132, 96136, 96137.
    1. Questioned the relevance of Medicare benchmarks for pediatric care, noting that pediatric testing takes longer than for adults.
  - A Clinical Psychologist and Clinic Owner, referenced that her clinic serves 83% Medicaid clients.
    1. Expressed frustration that assessment rates have only increased 1% in 3 years.
    2. Described a wage inversion where Master's-level therapists earn more than PhDs due to low assessment reimbursement.
    3. Referenced that Colorado's rates are comparatively low nationally.
- **MPRRAC Discussion:** Providers were prompted to share relevant codes in the chat, which included codes commonly used for identification, assessment, and brief interventions, as well as notes on billing restrictions and practice challenges. A few highlights:

  - The provider community emphasized shortages in autism evaluation access, noting that fewer than 100 ClinPsys across Colorado conduct ASD/IDD evaluations, with only 21 sites accepting Medicaid.
  - Several commenters flagged that codes like 96127, 96110, and 96113 are not billable by ClinPsys under current behavioral health billing guidance.
  - A consistent concern was that subsequent units (e.g., second hour onward) are reimbursed at significantly lower rates, despite continued complexity in pediatric evaluations that often last 4–6 hours.
- Ian Goldstein noted that not all psychologists or PsyDs are qualified for this work—it is highly specialized, especially for autism. He criticized the use of Medicare benchmarks, noting they are based on adults and not young children. He expressed skepticism about applying Medicare rates to pediatric populations.
- There was also discussion on specific outlier codes:
  - Megan Adamson flagged 96146 as an outlier at 425% of the Medicare benchmark.
  - Kate Leslie and Brian Gablehouse clarified that 96146 reflects brief screening done in a physician's office (e.g., GAD-7, PHQ-9) prior to referral and does not substitute for a full neuropsych evaluation.
  - Megan also raised concerns about 96110, especially when billed with the EP modifier, and recommended keeping the rate in alignment with similar codes.
- On the topic of rate structure for time-based codes, it was emphasized that pediatric testing is not front-loaded in complexity; rather, the complexity often continues or increases over multiple hours. Ian Goldstein pointed out that face-to-face testing in adult populations may last only one hour, while pediatric assessments often require 5–6 hours, making current rates for subsequent hours insufficient.
- Chat Log Highlights (during discussion)
  - We got these provider numbers purely from the neuro/psychological claims.
  - 3581 but only less than 100 providers (ClinPsys) that do ASD/IDD evals; 21 sites take MDC at all.
  - Understood, but worth teasing out Pediatricians (MDs) from Neuropsych (PsyD and PhD). MDs can’t do full neuropsyche assessments.
  - Primary identification 96110, 96127, G8431, G8510.
  - 96132/3, 96136/7 primarily. They are 10–15% less than masters level providers rate per hour, and 30–45% lower than if the PhD did MH therapy during that hour instead (MDC rates).
  - Mine are the ClinPsy codes. We absolutely need the Peds codes for them to identify, and refer for full evaluation.
  - 96127, 96110, and 96113 are not in the BxHealth billing manual as allowable to ClinPsys.
  - Would love to comment back to the question on 96127.
  - It is very common in adult neuropsychology for face to face testing to last only about 1 hour, so the reduced rates for subsequent units is potentially less impactful compared to a typical peds eval (I often bill 5–6 additional units).
  - Would also love to add 96116 – no benchmark.
- **MPRRAC Recommendation:** Ian Goldstein proposed a multi-part recommendation, which received unanimous committee support:
  - For any codes currently reimbursed below 100% of Medicare, raise them to 100% of the Medicare benchmark.
  - Align reimbursement for subsequent time-based units (second hour and beyond) with the initial hour, across the following code pairs:
    1. 96131 to match 96130
    2. 96133 to match 96132

3. 96137 to match 96136
4. 96139 to match 96138
5. 96113 to match 96112

- No rate reductions for any other neuropsych testing codes, including outliers like 96146 and 96110, with discussion noting that some may warrant future review but not downward adjustment at this time.
- Additionally, Ian recommended that 96110EP and related G-codes (e.g., G8431, G8510) be increased by 10%, to better support pediatric behavioral screening. Kate Leslie voiced her support for this recommendation.
- The recommendation received unanimous committee support.

12.12 Neurology

- **Presentation Notes:** Brian Pool reviewed slides 255-263; covering a range of data related to Neurology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comment was provided during this segment
- **MPRRAC Discussion:** Megan Adamson initiated the discussion by noting that several high outlier codes appeared to be EEG services that are unmonitored—meaning the patient is hooked up and then tracked remotely rather than being observed in real time by a clinician. She questioned whether these higher reimbursement rates were a holdover from pandemic-era billing policies, as unmonitored studies are currently being reimbursed at similar rates as monitored studies, despite differences in clinical intensity.
- Megan proposed the following rate adjustment framework:
  - For codes with a Medicare benchmark and a current rate over 140%, reduce rates to 100% of Medicare.
  - For codes below 80% of benchmark, increase rates to 80%.
- Ian Goldstein expressed support for the recommendation, and Christopher Maestas also seconded the approach.
- Next, Megan addressed codes without a benchmark, noting that the committee had consistently applied a 3% increase in those cases. She proposed the same here.
- **MPRRAC Recommendation:**
  - For benchmarked codes:
    1. Reduce rates for codes over 140% of the Medicare benchmark down to 100%.
    2. Increase rates for codes below 80% of the benchmark up to 80%.
  - For codes without a benchmark:
    3. Apply a 3% rate increase.

12.13 Primary Care Evaluation and Management

- **Presentation Notes:** Brian Pool and HCPF reviewed slides 264-280; covering a range of data related to Primary Care Evaluation and Management services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations. Slide 266 flagged preventive codes with asterisks, and slides 273–275 provided detailed breakdowns on preventive care codes and well-child visit utilization trends. Colorado Medicaid's average reimbursement is 98% of benchmark states, 86% of AAP rates, and only 55% of commercial insurance rates for well-child codes. HCPF emphasized that investment in primary care improves outcomes and reduces acute care use, citing studies and economic modeling showing large potential savings.
- **Public Comment (1):**
  - A Pediatrician at Peak Pediatrics spoke in strong support of increasing reimbursement:
    1. His practice serves a population that is 70% Medicaid.
    2. Described pediatric practices as being in crisis due to chronic underpayment, noting two closures in 2024 and difficulty retaining MAs and RNs, who are leaving for better-paying adult care roles.

3. Cited a shortage of primary care physicians and difficulties attracting new providers.
4. Urged that the "bread and butter" codes be brought to 100% of benchmark to ensure the survival of quality pediatric care in Colorado. Requested enhancements to:
    1. 99381–99385
    2. 99391–99395
    3. 99202–99205
    4. 99211–99215

- **MPRRAC Discussion:** Kate Leslie noted it was unusual and significant for HCPF to make such a strong recommendation. She reminded the committee of legislative directives to increase pediatric rates, reinforcing the need to take this seriously.
- Megan Adamson emphasized:
    - Pediatric preventive codes, which are age-based, should be brought to 100% of benchmark. Most are already in the high 90% range, making the adjustment minimal but impactful.
    - Code 99305 (moderate complexity nursing facility assessment) is reimbursed lower than the lower-complexity code 99304, and needs closer review for alignment.
    - Cervical cancer screening and DEXA scan codes, also preventive in nature, should be prioritized for increase as they are currently reimbursed at 70–80% of benchmark.
    - DEXA scans are also used in pediatrics for conditions like eating disorders, not just osteoporosis in older adults.
- Megan proposed use of G2211 as a designation code to flag longitudinal care delivered by PCPs, similar to Medicare's approach.
- A question was raised about telehealth premiums on E&M codes. Kevin Martin (HCPF) explained that telehealth rates were temporarily increased during the pandemic to overcome barriers to adoption, but have since returned to parity, and the group agreed a re-evaluation is appropriate.
- **MPRRAC Recommendation:**
    - For codes with benchmark rates:
        1. Increase all codes currently below 80% of benchmark to 80%.
        2. Increase pediatric well-child visit codes and adult preventive visit codes to 100% of benchmark.
        3. Bring up preventive services related to cervical cancer screening, DEXA scans, and potentially colon cancer screening to 100% of benchmark, where currently below.
        4. Consider supporting the G2211 code to help identify and enhance reimbursement for longitudinal primary care services.
    - For codes without benchmark rates:
        1. Apply a 3% increase to account for inflation and maintain alignment with prior categories.
    - Both recommendations passed with unanimous approval.

12.14 Radiology

- **Presentation Notes:** Brian Pool reviewed slides 281-290; covering a range of data related to Radiology services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment (2):**
    - Neuroradiologist at Denver Health; VP of the Colorado Radiologic Society:
        1. Emphasized the critical role of radiology in supporting all other specialties.

2. Noted the impact of any reductions at hospitals like Denver Health and Children's Hospital Colorado, where Medicaid patients make up a large share.
3. Advocated for maintaining at least 80% of Medicare reimbursement.

- Pediatric Neuroradiologist, Colorado Radiologic Society:
  1. Stressed that pediatric radiologists serve the most vulnerable populations, often during crisis.
  2. Radiology is not discretionary—it's essential for diagnosis and treatment monitoring.
  3. Called for appropriate reimbursement, especially for children who cannot advocate for themselves.

- **MPRRAC Discussion:** Megan Adamson opened by identifying codes reimbursed at over 140% of Medicare, without a clear rationale. She suggested bringing those down to 100%, and raising codes below 80% up to 80%.
- Ian Goldstein asked for clarity on why routine chest and abdominal exams are priced so high.
  - The Pediatric Radiologist explained that:
    1. These exams are core to radiologic diagnosis, especially in trauma and pediatrics.
    2. Although flagged as outliers, the actual dollar amounts are small, and the work requires significant training and expertise.
    3. Offered to support further review outside the meeting.
- Megan added that abdominal ultrasound for aortic aneurysm screening should be considered a preventive service and potentially excluded from reduction. Also, modifier 26 denotes the professional component of the service (e.g., radiologist interpretation), while TC refers to the technical component (e.g., imaging equipment and staff).
- MPRRAC members expressed concern that some high-utilization codes are being flagged, which is unusual for outlier adjustments.
- Megan clarified that the committee could exclude the top utilized outlier codes (e.g., chest and abdominal X-rays) from the reduction recommendation if desired.
- **MPRRAC Recommendation:**
  - For codes with benchmark rates:
    1. Raise all codes below 80% of Medicare benchmark up to 80%.
    2. Reduce all codes above 140% of Medicare benchmark down to 100%, excluding the following:
       i. Top utilized outlier codes (e.g., chest and abdominal X-rays).
       ii. Ultrasound abdominal aortic aneurysm screening, as it is USPSTF-recommended preventive care.
  - For codes without benchmark rates:
    1. Apply a 3% rate increase, consistent with prior service categories.
  - Both recommendations were unanimously approved

12.15 Respiratory

- **Presentation Notes:** Brian Pool reviewed slides 291-298; covering a range of data related to Respiratory services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comments were submitted or shared.
- **MPRRAC Discussion:** Megan Adamson noted outliers reimbursed at over 140%, suggesting these be considered for reduction to 100% of Medicare. She also supported raising all codes under 80% up to 80%.
- Ian Goldstein questioned why reimbursement has declined annually for some respiratory services.

- Megan explained this reflects Medicare trends: as a fixed funding pool, increasing services and technology mean unit reimbursement goes down, particularly for services that have been reevaluated or simplified over time.
- Ian raised concerns about the airway inhalation treatment code.
- Christopher Maestas clarified that the description in the spreadsheet was limited and that 94642 specifically refers to pentamidine inhalation for pneumocystis prevention, not general asthma treatment.
- HCPF confirmed they would look into 94642 further, since it's benchmarked to other states, not Medicare.
- The committee agreed to set aside a final decision on 94642 until the August meeting, pending further review.
- HCPF reminded the committee that any deferrals could reduce the impact of recommendations.
- **MPRRAC Recommendation:**
  - For codes with benchmark rates:
    1. Raise all codes under 80% of benchmark to 80%.
    2. Reduce all codes over 140% of benchmark to 100%, excluding code 94642, which was set aside for further review at the August meeting.
  - For codes without benchmark rates:
    1. Apply a 3% inflationary increase.
  - Both recommendations were unanimously approved.

12.16 Sleep Study

- **Presentation Notes:** Brian Pool reviewed slides 299-305; covering a range of data related to Sleep Study services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comments were submitted or provided for the Sleep Study category.
- **MPRRAC Discussion:** Megan Adamson acknowledged that many high outlier codes are unattended sleep studies, which often replace more expensive in-hospital studies and may justify higher reimbursement. However, she questioned whether benchmarks over 200% are appropriate and suggested considering a cap at 140%.
- Terri Walter noted that many patients begin oxygen therapy after sleep studies, suggesting a preventive value to these services.
- Ian Goldstein supported both Megan's and Terri's framing, noting:
  - Home sleep studies yield significant cost savings when compared to hospital-based options.
  - Even though some are high relative to benchmark, their actual cost is still low ($100–$150 vs. $800–$900).
  - Supported raising codes below 80% up to 80% and applying a 3% inflationary adjustment for non-benchmarked codes.
- Ian Goldstein and others agreed with Megan's proposal to cap unattended sleep study codes at 140%, maintaining an incentive without allowing for overly disproportionate rates.
- **MPRRAC Recommendation:**
  - For codes with benchmark rates:
    1. Raise all codes below 80% of benchmark to 80%.
    2. Reduce codes over 140% of benchmark to 140%, but only if they are unattended sleep studies.
  - For codes without benchmark rates:
    1. Apply a 3% inflationary increase.
  - All recommendations were unanimously approved.

12.17 Vaccines and Immunizations

- **Presentation Notes:** Brian Pool reviewed slides 306-312; covering a range of data related to vaccines and immunizations, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment (1):**
  - A Pediatrician at Children's Hospital Colorado urged the committee to:
    1. Prioritize increases in pediatric-specific administration codes to help maintain access and promote preventive care for children.
    2. Requested increases for: 90460, 90471–90474, 96372, and RSV codes 96380–96381.
    3. Warned that cuts would undermine years of policy work and disproportionately affect vulnerable children.
  - Chrstina Winship, HCPF's vaccine SME added:
    1. The state does not reimburse for the vaccine itself for members under 19 who qualify under the Vaccines for Children (VFC) Program.
    2. Vaccine administration is capped at the VFC regional maximum of $21.68; Colorado currently reimburses $21.51, or 17 cents below the cap.
    3. Expressed support for increasing rates to the allowable maximum and emphasized the importance of avoiding any reductions.
- **MPRRAC Discussion:** Committee consensus emerged around:
  - Raising vaccine administration codes to the regional maximum.
  - Adjusting other codes below 80% of their benchmark up to 80%.
  - For codes without a benchmark, applying a 3% inflation adjustment.
- **MPRRAC Recommendation:**
  - Raise pediatric vaccine administration codes to the federally allowed regional maximum.
  - Bring codes below 80% of benchmark up to 80%.
  - Apply a 3% inflation increase to codes without a benchmark.

12.28 Vascular

- **Presentation Notes:** Brian Pool reviewed slides 313-318; covering a range of data related to Vascular services, including new analysis, recap information, benchmark comparisons, top utilized codes, access to care, and MPRRAC recommendations.
- **Public Comment:** No public comments were submitted or provided for the Vascular category.
- **MPRRAC Discussion:** Megan Adamson and Christopher Maestas discussed outlier codes:
  - Two codes were identified as above 140% of benchmark.
  - If benchmarked to Medicare, Megan recommended adjusting these down to 100%.
- Two codes were also under 80%, and the committee supported bringing these up to 80% of benchmark.
- It was confirmed that the high outliers were benchmarked to Medicare.
- Ian Goldstein noted the low-utilization of some high outliers and voiced support for the standard approach.
- **MPRRAC Recommendation:**
  - Bring codes below 80% of benchmark up to 80%.
  - Reduce codes above 140% of benchmark down to 100%, if benchmarked to Medicare.

3. Questions and Feedback

There were 35 public comments made across both the July 17 and July 25 MPRRAC meetings.

4. Next Steps and Announcements

Next Meeting is on Friday, August, 22, 2025 from 9AM-2PM.

Contact information was also shared (see below):

Website https://hcpf.colorado.gov/rate-review-public-meetings

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5. July 25th Meeting Adjourned at 1:14PM