COLORADO
Department of Health Care Policy & Financing

Minutes of the Medicaid Provider Rate Review Quarterly Public Meeting

June 28, 2024

Colorado Department of Health Care Policy and Financing

303 E. 17th Avenue, Denver, CO 80203

Virtual Zoom Meeting, 9:00 a.m. – 2:00 p.m.

A recording of this meeting is available at this link

1. Call to Order and Welcome

Kim Kretsch, MPRRAC Chair, called the meeting to order at 9:02a.m. All 7 of the 7 members were present and participating remotely.

A. Members on Zoom/Phone

Terri Walter, MSN, RN, HopeWest, Hospice & Palliative Care
Ian Goldstein,
Kim Kretsch DDS, MBA Colorado Dentistry for Children in Brush CO
Vennita Jenkins, MBA, CEO Senior Housing Options, Inc.
Megan Adamson, MD, family physician from Lafayette Colorado
Kate Leslie, LCSW, Medicaid Mental Health provider
Tim Diesnt, CEO, Ute Pass Regional Health Service District

B. Department Staff Participants and Facilitators

Michelle LaPlante, Jeff Laskey, Kevin Martin, Cheyenne Gratale, Lingling Nie, Victoria Martinez, Amanda Villalobos, Ivy Beville, Amy Dickson, Christopher Lane, Gina Robinson from HCPF, Brian Pool and Erin Ulric from GPS Consulting (facilitators)

C. Other Participants

46 total participants were present at 9:02.

D. Housekeeping & Meeting Overview

Brian, Lingling and Dylan reviewed slides 2-7; including the agenda, housekeeping, meeting etiquette, rules of governance, accessibility, PHI, and the role of MPRRAC.

2. Chair/Vice Chair Term Discussion

The group discussed options for terms for the Chair and Vice Chair. Committee members agreed two years was a good recommendation. The members recommended that there is an annual election, and the vice chair becomes the chair elect and will become the chair after one year. Current terms for members are four years, with the opportunity to renew. Look for opportunities to stagger terms for the chair and vice chair in the

future, given the four year member term. There could be an opportunity to go back to the legislature to ensure continuity of MPRRAC membership.

Vote: There will be an annual election for the vice chair/chair elect. The vice chair (or chair elect) will serve a one year term and then will become the chair for a one year term.

- ***Kim motioned, Vennita second, all in favor.***

3. Meeting Minutes

No discussion. Unanimous vote for approving the minutes for the March meeting.

4. Meeting Structure, Purpose, Review of Services, and Methodology Updates.

Lingling reviewed the annual meeting structure on slide 9 and the purpose on slide 10, and the proposed services for review for 2025 on slide 11.

Vote: Move to accept the list for 2025 review.

- ***Megan motioned, Vennita second, all in favor.***

Kevin reviewed the reminders on slide 12. Committee members wanted to clarify that NEMT and EMT are distinct. Fraud investigation impacts NEMT (i.e. someone gets transportation to a doctors appointment) and EMT (ambulance or helicopter).

Lingling reviewed slide 13 to share the excluded code handling strategy.

5. Year 2 Services and Rate Comparison

Brian reviewed slides 15-16 to show the list of services being reviewed and the benchmark for each service we are covering today.

6. Year 2 Services Data Analyses/Feedback

A. Emergency Medical Transportation (EMT)

Brian and Kevin reviewed slides 17-18 which contained a recap of the analysis and a summary of findings. Brian then shared the new analysis on slide 19.

Public Comment – no public comment.

Committee Discussion – main points:

- EMS is the most expensive treatment option. Many EMS agencies will arrive on scene and provide treatment in place, but they are not reimbursed. There is Federal legislation on treatment in place for Medicare. There would be significant cost savings associated with allowing treatment in place to be a benefit in Medicaid.
- HCPF is looking into treatment in place as a payable benefit. At the moment figuring out what bucket of funding would be used to cover this service. HCPF hopes to have more concrete information later this year.
- Average net savings to Medicare was $537 when they were treated in place. Tim will send information to Courtney at HCPF.
- Can MPRRAC make a recommendation on this? Yes – it will be a non-fiscal recommendation or a policy change.
- Mental health billing is challenging due to the license requirements of providers and there is a shortage of those providers. Tele-health is a good option.
- There are 12 codes for EMT. The list of codes is even smaller for ambulance services which is the most utilized.

Committee Recommendation:

- *Explore policy modifications to pay for mobile crisis response and community integrated health.*
- *Pay for treatment in place*
- *Increase EMT codes, including A0021, to 80% of the benchmark and leave the other codes alone (there are no codes above 100%).*
- *Tim made motion, Vennita seconded. All in favor.*

B. NEMT

Brian recapped the analysis on slide 23. There is a fraud investigation currently pending, so they do not have current year data, but still need a recommendation.

No public comment.

Committee Discussion – main points:

- Let's be consistent, given how high these codes are, we may need to reduce them.
- There are 19 codes and 6 codes are above 100%.
- It's tricky to make a decision today because there are no stakeholders at the meeting today. There is a list of codes, but the members want to understand which codes are high. There aren't outliers for this services due to the fraud.

Committee Recommendations:

- *Move the NEMT codes to 80% of benchmark.*
- *The members had consensus around this recommendation.*

C. Qualified Residential Treatment Program (QRTP)

Brian recapped analysis on slides 26-27 and new analysis on slide 28-29.

No public comment.

Committee discussion – main points:

- There is one code at 50% and the committee would support the increase to 80%.
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Committee Recommendations:

- *Raise the rate for the QRTP code to 80% of the benchmark.*
- *The members had consensus around this recommendation.*

D. PRFT

Brian recapped analysis on slides 33-34 and new analysis on slide 28-29.

No public comment.

Committee discussion – main points:

- This is a challenging code, since there are not enough beds in state. Out of state placements are extremely expensive, and we want kids closer to family and community. MPRRAC and codes don't support the infrastructure, which is a serious issue in terms of availability of care.
- MPRRAC supports BHA efforts to increase in-state placements, and the committee would be supportive of increasing the rate.
- There may be USDA grant funding to help with the infrastructure development.
- There are some significant changes with HCPF and how they reimburse for residential care in

2025. They are trying to make sure they can better match reimbursement to the needs of the child.
- Raising the rate is not going to be sufficient to increase availability services in this space given the infrastructure needs.
- Can we go above 100%? It's not consistent, but we are sending people out of state, and we could make an impact to provide access to care for kids.

Committee Recommendations:
- *Committee recommends to raise the rate to 100% and going to 120% of benchmark with highest acuity patients to decrease out of state placements.*
- *The members had consensus around this recommendation.*

E. Physician Services – Sleep Studies

Brian reviewed slides 37-38. New analysis on slides 39-40.

No public comment.

Committee Discussion:
- Medicare is decreasing their rates, so we need to be careful when reviewing the benchmark. The group does not know why Medicare rates have decreased.
- There is one code with multiple modifiers and the information is on page 4 of the appendix.
- With respect to sleep studies, it may be helpful to keep home based sleep studies higher, it is more affordable to do this instead of a in a facility.
- The members did not know the three codes without benchmarks.

Committee Recommendations:
- *The committee recommends moving all codes to 80% of the benchmark, with the exception of leaving unattended (home-based) sleep study codes as is for cost-savings.*
- *The committee recommends matching the code with no benchmark G0399 to be similar to the rates f or codes G0398 and G0400.*
- *The members had consensus around this recommendation.*

F. Physician Services – EEG Ambulatory Monitoring Codes

Brian reviewed slides 44-45. New analysis on slide 46.

No public comment.

Committee Discussion – main points:
- There are some big outliers for this service, with one code receiving more than 300% of benchmark.

Committee Recommendations:
- *This services seems to be well-utilized, and the committee recommends decreasing codes 95708 and 97714 to 100% and increasing code 95715 to 80% of benchmark.*
- *The members had consensus around this recommendation.*

G. Fee-for-service Behavioral Health SUD Codes

Brian reviewed slides 49-50. New analysis on slide 46.

No public comment.

Committee Discussion – main points:

- There are some big outliers for this service, with one code receiving more than 300% of benchmark.
- Majority of services are still in the RAE in the capitated program. This is a backup code when RAE systems fails a Medicaid member, the provider can go to the state and get reimbursed for the services.

Committee Recommendations:

- *Recommendation to increase the rates to 80% of the benchmark.*
- *S9445 is the one code without a benchmark to increase by the same proportionate amount as the remainder of the recommendation.*
- *The members had consensus around this recommendation.*

H. Home Health Services

Brian reviewed slides 49-50. New analysis on slide 46.

No public comment.

Committee Discussion – main points:

- There are some big outliers for this service, with one code receiving more than 300% of benchmark.
- Majority of services are still in the RAE in the capitated program. This is a backup code when RAE systems fails a Medicaid member, the provider can go to the state and get reimbursed for the services.

Committee Recommendations:

- *Recommendation to increase the rates to 80% of the benchmark.*
- *S9445 is the one code without a benchmark to increase by the same proportionate amount as the remainder of the recommendation.*
- *The members had consensus around this recommendation.*

I. Home Health Services

Brian reviewed slides 54-55. Lingling shared the fiscal impact on slide 56, reminding members that any change to these rates will have a significant fiscal impact. New analysis on slide 57.

Public comment – one (1) public comment:

- Pediatric home health stakeholder shared where they fall in the percentages – encourage the members to look at the codes to see what might be dropping – if they fell to 75% that would be a huge impact on providers.

Committee Discussion – main points:

- This service can be provided by a family member if they are a CAN or RN and work for a licensed home health agency, they do not compensate individual family members. It is not a waiver service.
- Outliers are revenue codes for CNA services.
- They are not reimbursed for travel for these services, the Federal government does not allow for transportation to be billed separately. HCPF shared that CMS does not currently allow for a separate rate for travel, it must be rolled into the rate. CDLE requires employers to reimburse providers for travel time, but not necessarily mileage.
- HCPF is using other states Medicaid for the benchmark rather than Medicare.
- Raising to 80% seems like it might not be feasible. There is interest in the cost-savings that this service reflects. Members agree that targeting the CNA codes is cost effective. If we raise the two outlier codes to 80%, the fiscal impact is almost $100M (~$50M from General Fund).
- Home Health Agencies may also provide HCBS services, but not the majority. They work in tandem and will work together, but these are typically separate.

- Home Health codes without benchmarks include telehealth codes.
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Committee Recommendations:

- *Recommend increasing the overall service to 75%, with HCPF determining which codes to modify that will have the greatest impact on access. Do not reduce codes above 100% to below 100%. Any increase in utilization will be a cost benefit to the state.*
- *The committee recommends increasing Home Health codes without benchmarks by 3%.*
- *Not service specific: committee members would like more data on individual codes where possible (it is not always possible).*
- *The members had consensus around this recommendation.*

J. Pediatric Personal Care

Brian reviewed slides 61-62.

No public comment.

Committee Discussion – main points:

- The members decided to align the HCBS – Pediatric Personal Care available under the community first choice authority. This benefit will remain the same, but it could be a challenge if the rates do not align.

Committee Recommendations:

- *Committee members recommend rate alignment with Community First Choice with HCPF presenting the rates in September. Whichever rate is higher would be the rate selected*
- *The members had consensus around this recommendation.*

K. Private Duty Nursing

Brian reviewed slides 65-66.

Public Comment – there were four (4) public comments:

- Colorado is substantially below the rates for other states, so the 88% benchmark doesn't make a lot of sense. There is an analysis of rates done that should be shared with the committee. Keeping children in the home, and being able to discharge from a facility is a tremendous cost savings.
- There is analysis of the rates across the country and the committee should take into consideration the cost savings that is provided. The committee was provided with the Menge rate analysis. Committee members confirmed review.
- This type of care if challenging for the parent provider team, and if PDN care is not available, they may need to stay in the hospital. Giving kids opportunity to be and stay with family is critical. Skills for providers are unique and should reflect the independent need of PDN's.
- Colorado ranks 17th lowest in payment rates for RN's and 11th lowest for LPN's and cost of living is higher than other states. This is a priority for the CO legislature. Medicaid spending will be $1,300 less per day using PDN than hospital care.

Committee Discussion – main points:

- There needs to be a crosswalk between revenue code and HCPF code to get there. There is a chart in the report that shows the rates that stakeholders are asking to be increased.
- Members agreed that they need to maintain an element of consistency to the benchmark. If there is anything below the benchmark. There are two codes over the benchmark ratio, and three codes are under. The two codes that are above the benchmarks are at 89% and 95%. Removing rev codes and instead looking at CPT payment codes will be a good policy recommendation.

- There were seven states used for the benchmark – they will send the rationale for why those states were selected.

Committee Recommendations:

- *Move the two revenue codes that are above 80% (T1000 TE and T1000 TD) to 100% of the benchmark.*
- *Policy recommendation: change the analysis from using revenue codes and instead analyze CPT payment codes to ensure comparison for the benchmark.*
- *The members had consensus around this recommendation.*

L. Home and Community Based Services (HCBS)

Brian reviewed slides 69-73.

Recommendations for HCBS:

- *MPRRAC recommends that if there are services with different rates, we align at the higher rate. The members had consensus around this recommendation.*
- *JBC increased the rate for HCBS, MPRRAC recommendations is to uphold JBC decisions and to ensure that salaries do not get decreased. The members had consensus around this recommendation.*

1. HCBS ADL Assistance

Brian reviewed slides 69-73.

Public Comment – there was (1) public comments:

- They represent all the HCBS services, but will comment now. HCBS exists to keep people out of institutional settings. Designed to be cost savers for the state. IDD providers are almost solely reliant on Medicaid reimbursements, since there are no other payers. There are concerns with the states that were selected for benchmarks and would like more information on services without a benchmark.

Committee Discussion – main points:

- There are 21 codes without benchmarks (slide 79) among 71 total codes.
- There are many codes below 80%, and all of these waiver services are designed to be cost-savings.
- These services serve members with IDD, brain injury, spinal cord injuries, and they include pediatric populations.
- The committee discussed the possible recommendations below, but decided to create another meeting time for HCBS.
    - *HCBS Overall - MPRRAC recommends all codes be moved to a minimum of 80%.*
    - *HCBS ADL (applicable to other services within HCBS as well) - If 80% benchmark is not possible for all codes, increase highly utilized codes under 80% by at least 5%. MPRRAC also recommends alignment with Community First Choice rates.*

M. Future Meeting Discussion

The group ran out of time to consider HCBS services, and decided to set another meeting time in the next two weeks. Members requested more specific data on the codes, including what each outlier was, as well as the no benchmark codes. HCPF will send more information before the next meeting, top 10 codes based on utilization. If stakeholders have specific codes that they want changed, the members requested that was shared before or during the next meeting.

7. Next Steps

Next meeting will be July 12th from 10-1 and will focus on HCBS. Draft notes will go to committee

members for review. We will approve the minutes after the next meeting once the HCBS recommendations are complete.

Contact information was also shared:

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

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8. Meeting Adjourned at 1:57 p.m.