COLORADO
Department of Health Care Policy & Financing

Minutes of the Medicaid Provider Rate Review Quarterly Public Meeting

March 29, 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 9:02 a.m. All 7 of the 7 members were present and participating remotely.

A. Members on Zoom/Phone

Ian Goldstein, MD, MPH, CEO - Soar Autism Center
Kate Leslie, LCSW, Medicaid Mental Health Provider
Kim Kretsch DDS, MBA, Colorado Dentistry for Children, LLC in Brush CO (Chair)
Megan Adamson, MD, family physician from Lafayette Colorado (Vice Chair)
Tim Diesnt, CEO, Ute Pass Regional Health Service District
Terri Walter, MSN, RN, Chief Administrative Officer and Compliance Officer, HopeWest
Vennita Jenkins, MBA, CEO Senior Housing Options, Inc.

B. Department Staff Participants and Facilitators

Michelle LaPlante, Kevin Anderson, Jeff Laskey, Kevin Martin, Kimberly Preston, Lingling Nie, Suzy Dossou, Wei Deng, Alaina Kelley, Amanda Villalobos, Amy Dickson, Angela Goodell, Cassandra Keller, Danielle Comstock, Dylan Marcy, Emily Walsh, Karin Stewart, Maddie Quartaro, Victoria Martinez, Trish Grodzicki, from HCPF, Brian Pool and Erin Ulric from GPS Consulting (facilitators)

C. Other Participants

52 total participants were present at 9:03.

D. Housekeeping & Meeting Overview

Michelle, Kevin and Dylan reviewed slides 2-9. Slides included meeting etiquette, rules of governance, accessibility, PHI, and the role of MPRRAC.

Discussion: Would like to increase transparency between MPRRAC recommendations and HCPF recommendations. If HCPF disagrees, the committee would like to understand where there is

disagreement. The rates are changing continuously, and HCPF will do their best to keep the committee apprised while also maintaining consistency to a point in time for benchmarks.

2. Meeting Minutes

Motion to approve November meeting minutes made by Kim, seconded by Vennita. No objections. Motion passes.

3. Meeting Structure and Purpose

Michelle reviewed slides 11-12 on the meeting structure and purpose.

4. Updates on Analysis and Metrics Used

Kevin reviewed slides 13-14 and shared improvements that the HCPF team has made based on feedback provided by the committee in the last cycle.

Discussion:

- The committee will likely narrow down the data points that are most relevant as they work through the process this year. For now, more data is helpful so that the committee can understand what is helpful.
- 2022-2023 utilization data is used because we need a full year of claims data, and the analysis is started in the prior calendar year. So, we will always be a year behind in rates. Updating the analysis causes confusion.
- There is a summary of insights slide that the HCPF team put together for each service.
- CIVIHC is providing new data on price per service, but this data is challenging because claim data does not compare apples to apples (i.e. a claim may be submitted once (acute care) or weekly for ongoing care).

5. Year Two Services

Brian reviewed slides 12-13 and shared the schedule for service review.

6. Year Two Services – Data Review

A. Emergency Medical Transportation

Brian and Kevin reviewed slides 18-20 which contained analysis for Emergency Medical Transportation.

Public Comment – there was one (1) public comment.

- We need to keep people with disabilities in mind and the committee needs to do more to distinguish who is being served by providers, as folks with disabilities or more complex needs may not be provided with care due to cost.

Committee Discussion – main points:

- There was a question about the two providers who had steep declines in participation. One was in Weld and one in Las Animas. One served 78 members in FY21 and dropped to 41 members in FY22 and 1 member in FY23. The other served 16 members in FY21, then 4 in FY22 then 1 in FY23.
- One focus of the committee is trying to get rates up to 80%, and we are not there. Where are we with previous recommendations, and where are we with trying to get to 80% of the benchmark.
- There are only 12 codes in EMT, but it becomes very complex to evaluate the cost

between an ambulance and a helicopter.

- Benchmark by procedure code could be challenging for some services due to the volume of codes.
- Is the benchmark appropriate?
- There is a dis-incentive to treat onsite versus transport in an ambulance to a hospital emergency room. Rural communities are struggling with transportation.
- If there are services provided that are of high value to members, we should try to make sure that those are reviewed.
- HCPF can commit to giving breakdown by code. They may have to blind utilization by code due to PII reasons.
- EMT is involved in mobile integrated health to try to keep people out of hospitals, but mobile integrated health and treatment in place are not compensated by Medicaid.
- Request for data: Can we also show the state level benchmark and Medicare benchmark by code? The only codes we compare to benchmark with other states are ones that don't have a Medicare benchmark. Or if Medicare rates are not appropriate.
- We need to consider the payer mix for EMT services – looks like the commercial side is doing really well, but it is only 10-15% of who are paying.

B. Non-Emergent Medical Transportation (N-EMT)

Brian recapped slide 23.

Public Comment – there was no public comment.

Committee Discussion – Main Points:

- Back to the same comment about individual codes, it's hard to make sense of a range that goes from 63.59% - 161.78%.
- Complex issues between N-EMT, and EMT and how they interact with each other. These services are expensive per person.
- One thing going forward is that it is very helpful to hear about the circumstances that it puts patients in regarding costs, and how we can consider downstream and upstream effects.
- Home health is also important, there are so many things that could happen there that could improve overall health and accessibility. Want services to help each other and working more interdisciplinary to provide better services.

C. Qualified Residential Treatment Programs (QRTP)

Brian recapped slides 26-28. New analysis included the top 10 codes, county level utilizer to providers rates, and outliers. Outliers included 140% above the benchmark.

Public Comment – there was no public comment.

Committee Discussion – Main Points:

- Use the regular providers. There are five categories, so HCPF typically uses claims data to identify the rendering provider and categorize them.
- This year is really different from last year – last year there were a lot of outpatient services. The services this year are very specialized and specific to Medicaid. For example: a family member can provide care, and they can be paid by Medicaid. Because we have so many waiver services, this year will look different from last.
- Penetration rate: there are still several counties that either don't have a need or are

seeing providers increasing? Very common that counties do not have a residential treatment option for children and adolescents. There is a big push to have more residential facilities for youth. There is a large access to care issue.
- The appendix has urban, rural and frontier data, so the members can review the trends.
- The states are selected by the contractor (Optimus) who works across the nation and approved by the policy team at HCPF. For most services, external stakeholders were outreached as part of the process as well. The committee members asked if they could learn more about the rationale for the selection of benchmark states. There is interest in understanding more nuances than just urban and rural, and there was desire to understand more about populations (i.e. people with low incomes, racial/ethnic diversity, severity and acuity of cases, etc.)

D. Psychiatric Residential Treatment Programs (PRTF)

Brian reviewed slides 31-34.

Public Comment – there was no public comment.

Committee Discussion:
- This is a crisis. 40% of placements out of state is a huge waste of money. If we increased these rates and could reduce the out-of-state placements we could save the state money.
- QRTP and PRTF are usually used to foster care or kids who are in the system. These are facilities are typically only used by Medicaid.
- Is there more preventative care available? Yes and no – it's a complex issue.

E. Physician Services: Sleep Studies

Brian reviewed slides 37-39.

Committee Discussion:
- Did the benchmark go down? It seems like this is high. The price for service is very sensitive, so don't have an answer.
- The committee needs to be aware that the cost to provide the service isn't decreasing and need to be aware of that when reviewing benchmarks.

F. Physician Services –EEG Ambulatory Monitoring Codes

Brian reviewed slides 42-44.

Public Comment – there was no public comment.

Committee Discussion:
- Would be helpful to do another wave of outreach on the services that have not had public comment.
- Not seeing a large access to care issue within this service. For some codes it is low compared to Medicare.

G. Fee-for-service Behavioral Health SUD Codes

Brian reviewed slides 47-49.

Public Comment – there was one (1) public comment.

- Recommendation that are made about rates for fee-for-service sometimes impact the managed care program, as they will reference the fee-for-service rate when doing negotiations.

Committee Discussion:

- If there is a way to get data on different lines of service, that would be helpful (residential versus outpatient)? HCPF has a breakdown of specific codes.
- Not sure what to make of panel size. More people are getting into mobile integrated health but aren't getting reimbursed for this.
- 90% of the services are provided through the RAE's, this is a smaller subset of services.
- Reason there seems to be a declining trend, is that the growth for total visits outpaced the growth for telemedicine.
- Majority of services are captured by RAE system. Two criteria – when a member is not enrolled in a RAE or when a condition is not a covered diagnosis of the RAE (not applicable for this service). The only reason a member would receive a fee-for-service benefit is because they are not assigned to a RAE.

H. Home Health Services

Brian reviewed slides 53-55.

Public Comment – there were three (3) public comments:

- Believes that rates are limiting access to services. It's complicated by the fact that parents are allowed to be providers to their own children or dependents. This greatly skews the data.
- Colorado has a much different long term home health makeup than other states. Increased minimum wages that are popping up are creating challenges in recruiting and maintaining staff.
- Reimbursement rates are not keeping up with wage pressures. There are other neighboring states that are providing this type of care, and their rates are higher.

Committee Discussion:

- Two questions for stakeholders:
    - Is Medicaid reimbursement for travel (mileage and gas) and that is impacting rural counties. Have heard that transportation used to be reimbursed and now is not being reimbursed. Stakeholders confirmed this is the case. HCPF shared that they are not allowed to pay for travel (Federal requirement). In addition, reimbursement is lower with Medicaid than Medicare.

I. Pediatric Personal Care

Brian reviewed slides 57-59.

Public Comment – there was one (1) public comment:

- Vastly underutilized services for kids who have developmental disabilities. The reimbursement rate is so low, there are almost no providers. This is a service that may as well not be there given the utilization. July 2025 there will be a shift in this service as legally responsible adults will be allowed to provide care.

Committee Discussion:

- Per 15 minutes, $6.11 outside of Denver County, Denver County $6.16. And no reimbursement for travel. Parent CNA program reimburses significantly more.
- Pediatric personal care is provided by a care provider who is not trained or licensed. The agency does need to be licensed.
- HCPF SME shared that their personal care rate is significantly higher than the current Pediatric Personal Care Rate, so they are looking to align those rates, so everyone can have access to a personal care rate that is sustainable for agencies. Want people to receive the right services at the right time, so they can choose how best to receive services. Looking to support the goal of aligning the rates across all of personal care.
- Members encouraged stakeholders to work with the department determining the correct benchmarks.
- One other piece of context was that during the Public Health Emergency there were more children with access to CNA services. More kids were eligible due to a waiver of requirements.

J. Private Duty Nursing

Brian reviewed slides 62-64.

Public Comment – there was six (6) public comments:

- Private duty nursing is like setting up an ICU in the home. The rates may not reflect recent increases in other states. They also know that hospitalization is a much higher cost for these patients. Round the clock care. It's very different from home health in terms of severity. This service keeps people out of the hospital. When they can't find services, families are forced to make life changes. Please allow Menge to come speak at a meeting to share their analysis.
- Most states in the last three years have increased rates anywhere from 20-70%. We have a parent CNA program. There are a lot of cost savings that that program allows, and we would hope that the money saved would be sent back to the PDN to keep wages stable and continue to provide services.
- Would recommend that the committee take the time to review the Menges Report. This is a very, medically fragile pediatric population. There are several other states that have just updated their PDN rates, so to not account for that is a disservice.
- Urging to meaningfully increase the PDN rates – other states are increasing their rates right now. The report that was commissioned from Menges Group found they need a 40% increase for RN's and 52% for LPNs to drive utilization. Kids are currently in hospitals, which could be receiving care at home.
- Would appreciate engagement with providers during this process. They request more stakeholder involvement with the committee to make sure any decisions are meaningful.
- The family experience is at a crisis level. There are family members who can't find care and are not sleeping and at a breaking point. At risk of institutionalizing kids that could be home.

Committee Discussion:

- Confirmed that the committee will be able to see the Menges report. https://themengesgroup.com/2024/03/12/costs-and-benefits-of-enhancing-private-duty-nursing-payment-rates-in-colorados-medicaid-program/
- Stakeholders shared specific codes that they want reviewed.
- Committee members asked to see any research on hospital avoidance, and this is included in the study.

- HCPF has concerns about using the managed care rates,
- Other resources shared in includes:
  - https://hcpf.colorado.gov/sites/hcpf/files/10B_CO_FeeSchedule_PDN_07.2023_V1.0.pdf
  - Stakeholders provided additional files which will all be downloaded and saved in the MPRRAC folder.
- The committee asked for a chance to absorb and review the information provided.

K. Home and Community Based Services

HCPF created a number of categories within HCBS to allow for better analysis of the different codes and services.

• HCBS – ADL Assistance and Delivery Models

Brian and Kevin reviewed slides 70-72.

Public Comment – One (1) public comment was provided:

- Providers don't necessarily provide services in all of the different waivers. This category is personal care and basic homemaker. These are two of the historically underpaid rates. In 2025 they will be moving out of the waivers into the Medicaid State Plan, and this will require HCPF to consolidate rates across personal care. They urge the committee to select at least the highest rate that is currently being used for personal care.

- IDD providers code over 100% down to 100% which resulted in the decrease.
- There is an urgent need to revisit these codes.

Committee Discussion:

- What's the issue with Hinsdale County? There is no utilization data from the last three years.
- Telemedicine accessibility took a big drop because this is primarily an in-person service.
- Members are predicting a potential problem that is going to come with the transition of some waiver services to the State plan. Members requested HCPF to show how some of these services are being combined with other services for the 2025 rollout.
- There was really high utilization of telemedicine during COVID, but this service is much better provided in person given the type of care.
- Services are not being combined, but moving into the state plan, and the policy team can prepare some information on how this alignment might be happening.
- In the June meeting, can we please see the waiver-by-waiver rate by code for the committee to include in the report.

• HCBS – Behavioral Services

Brian reviewed slides 75-77.

Public Comment – One (1) public comment was provided:

- Many providers are maintaining waiting lists for these services. Stakeholders hope to see a rate increase to reduce the waiting list.

Committee Discussion:

- Same as before – would love to hear how these types of behavioral health services will be condensed. HCPF confirmed that behavioral health services will not be condensed, only a handful of waiver services will be moved to CFC.
- The ideal state is to move all waiver services to align with other rates for those services, so that it doesn't matter what waiver is being used, the reimbursement is all the same.

- Provider participation looks pretty skinny in this space.
- The penetration rate is pretty bad, and this data was striking for some members.

• HCBS – Community Access and Integration

Brian reviewed slides 80-82.

Public Comment – Two (1) public comments were provided:

- Wanted to call out supportive employment services. These supports can lower costs in other areas, as they improve health and quality of life. There was an independent rate study that asked for a 30% increase in job development, 10% increase in job coaching. There is funding for training that will expire at the end of the state fiscal year, and they would like to consider a rate increase to cover the cost of training.

Committee Discussion:

- Non-medical transportation is included in this benefit. How is this different from N-EMT? It's a waiver program for people with IDD and also available to individuals with other waivers as well. It is not allowed to be used in place of N-EMT – only utilized to transport folks to other waivered services or in the community.
- Please share the data sources behind the rate increases from public comment.

• HCBS – Consumer Directed Attendant Support Services (CDASS)

Brian reviewed slides 84-86.

Public Comment – No public comment was provided:

Committee Discussion:

- How is provider being defined? The providers for this are not typical, for CDASS the members themselves are the employers. They have two FMS Vendors who are contracted by the state and run payroll for the members to pay the wages to whomever is providing services.
- Members didn't realize MPRRAC could have comment on the hourly wage of these workers – what is the hourly wage? The members are able to set a wage themselves. The members receive a unit rate of $7.20 per 15 minutes of CDASS services.

• HCBS – Day Program

Brian reviewed slides 89-91.

Public Comment – One (1) public comment was provided.

- Providers are maintaining waiting lists for these services, and the rates are not sufficient to fully staff their programs. The rates have not changed for about 15 years, and the provider ratio was higher, so it's important to know that the same staffing ratios are being used.

Committee Discussion:

- No committee discussion

• HCBS – Professional Services

Brian reviewed slides 94-96.

Public Comment – One (1) public comment was provided.

- Pediatric population served into adulthood. There were findings in music therapy, massage therapy, and therapeutic support and the stakeholder wanted to ensure that data was able to be reviewed by MPRRAC. When families have children, it never makes economic sense for them to stay in the workforce. They are providing childcare for their therapists and have been able to bring therapists back into the workforce.

Committee Discussion:

- Ian has seen some of the issues with providers leaving the field.
- All of these services will be staying within their own waivers and not being moved to the state plan.

• HCBS – Residential Services

Brian reviewed slides 99-101.

Public Comment – One (1) public comment was provided.

- Hard because there are so many different residential models contained in this category. High benchmark may be driven by individualized rates. Their community is struggling with Group Rates. One other model utilized is three bed homes, where provider staffs the home. Because they are smaller homes, they don't have the economies of scale to work within their rate. Would be helpful to see a more detailed breakout of that.

Committee Discussion:

- Were there specific types of residential services? Group, Individual, and Individual Host Home would be helpful to see broken out.
- Curious if any stakeholders have any comments on the states chosen for the benchmark.
- This is something the committee struggles with every year. The benchmark seems high, but we hear from stakeholders that they can't continue, and providers aren't able to continue.
- More data can be submitted by stakeholders, and they will provide deeper data on what has been shared today. What we hear nationwide is that HCBS is underfunded everywhere.
- It will be very helpful to get more data especially in areas when Medicare data doesn't exist.
- There is an acknowledgement that there is a finite pot of money, that's part of what makes this work so challenging.

• HCBS – Respite Services

Brian reviewed slides 104-106.

Public Comment – One (1) public comment was provided.

- Another area that would be helpful is to have a comparison to the benchmark. During the pandemic there was a temporary rate increase of 20-25% and that was the first time that members said they were in the black when providing this service.
- Paying for basic childcare rates for neurotypical children. When respite rates turn out to paying people less than typical rates, it is impossible to get providers. Families end up having to subsidize the services, which shouldn't be happening.

Committee Discussion:

- If a family member needs respite care, they are technically not allowed to add to their

rate (i.e. if Medicaid reimburses at $18, the family is not allowed to add an additional $7/hr. to get someone hired at $25/hr.).

- **HCBS – Technology, Adaptations, and Equipment**

Brian reviewed slides 109-111.

Public Comment – No public comment was provided.

Committee Discussion:

- Will the committee receive additional information on this section? Some services are expensive, and some are not. The committee is missing scatterplots to evaluate the codes – that was really helpful information. HCPF will see what they have capacity to do here.

- **HCBS – Transition Services**

Brian reviewed slides 114-116.

Public Comment – No public comment was provided.

Committee Discussion:

- Question around CBS services – it seemed like there was a wage bump adjustment for HCBS waivers – is that factored in? Yes, through a couple of different funding mechanisms, HCPF received funding to pass through a base wage increase to direct care workers. That base wage increase is being factored into this analysis.

7. Next Steps

Michelle reviewed slides 119-Next meeting is Friday, June 28, from 9:00-2:00pm. The June meeting is to create the recommendations for the JBC and the MPRRAC folder will continue to be updated.

Contact information was also shared:

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

Lingling Nie
Rates Review and Research Section Manager
Lingling.nie@state.co.us

Michelle LaPlante
Rate Review Stakeholder Relations Specialist
michelle.laplante@state.co.us

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

8. Meeting Adjourned at 1:29 p.m.

Motion to adjourn made by Terry, seconded by Kate. All in favor. Motion passes.