

Medicaid Rate Review Quarterly Public Meeting

June 25, 2021
9:00 AM - 12:00 PM

Presented by: Eloiss Hulsbrink, HCPF
Tim Dienst, MPRRAC Chair



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New & Returning Members



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Our Mission:

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.



Agenda

9 AM Call to Order, Welcome, & Meeting Overview

9:10 AM Meeting Minutes

9:15 AM 2021 Medicaid Provider Rate Review Analysis Report

9:35 AM Year One Services Working Recommendations - Transportation

+Break – 10:10 a.m.

10:20 AM Year One Services Working Recommendations – HCBS Waivers

11:30 AM Year One Services Working Recommendations - TCM

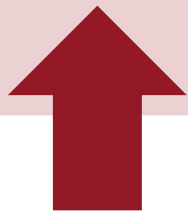
11:50 AM Next Steps & Announcements (adjourn at 12 PM)



Quarterly Meeting Purpose & Scope

June

- Allow time for feedback on Analysis Report
- Share Draft Recommendations
- Allow time for feedback and/or considerations



August/September

- Share refined recommendations
- Allow time for feedback on recommendations
- Annual committee member training

November

- Feedback on Recommendation Report
- Introduce next year of review service groupings
- Review data metrics in rate review process
- Allow time for feedback on data considerations

February

- Share preliminary data analysis results
- Allow time for feedback on data analysis and considerations for report conclusions

Meeting Purpose

- Meeting purpose is for the Department to receive feedback from stakeholders and the committee, including:
 - for the Department to answer questions and receive feedback from both stakeholders and the committee about the 2021 Medicaid Provider Rate Review Analysis Report
 - for the Department to briefly present its draft recommendations and key considerations, and then receive feedback from both stakeholders and the committee

Department's Role

- The Department's role is to:
 - provide policy and program information
 - answer questions as needed
 - keep the meeting on track with time and scope
 - create an inclusive and receptive space to receive feedback from the public

Meeting Etiquette

- Honor the agenda
- Stay solution and scope focused
- Direct policy questions to the Department policy experts
- Identify yourself before speaking
- Honor and respect everyone
- Q & A box

Protected Health Information (PHI)

- Protected Health Information is individually identifiable information relating to the past, present, or future health status of an individual.
- Information such as diagnoses, treatment information, medical test results, and prescription information are considered PHI under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact/emergency contact information.
- This meeting is recorded and will be made publicly available on the Department website.
- Shared PHI may result in the portions of the meeting recording being deleted and delays posting the meeting recording.



Meeting Minutes

February 2021



Stakeholder Engagement Guiding Principles

The Department will:

- Thoroughly and thoughtfully evaluate all questions and feedback.
- Identify what feedback can be incorporated now or potentially in the future.
- Transparently communicate the outcomes of feedback and questions.
- Refer individuals to appropriate Department resources for out-of-scope topics.

Rate Review Guiding Principles

The Department will:

- Thoroughly and thoughtfully evaluate services within and across benefits.
- Strive to promote member access to quality care and provider retention.
- Be guided by **recent data analyses and evidence-based research** and best practices.
- Work to identify methods to collect meaningful data when there an absence of evidence or when conflicting evidence or feedback exists.



Rate Review Process Timeline & Status

2021 Analysis Report

- Published June 15, 2021
- Informs Department recommendations
- Feedback from stakeholders and committee members (today)

2021 Recommendation Report

- Share draft Recommendations (today)
- Refine draft recommendations for August 27 meeting based on feedback and additional research
- Use feedback from August 27 meeting and additional research to inform 2021 Recommendation Report

Next Steps

- 2021 Recommendation Report published November 1, 2021
- Department initiates implementation of non-fiscal recommendations
- Department initiates implementation of fiscal recommendations upon state and federal approval

2021 Medicaid Provider Rate Review Analysis Report



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Conclusions

- Analyses suggest the following service rates were sufficient for member access and provider retention:
 - HCBS Waivers
 - BI, at 116.80% of the benchmark
 - DD, at 103.81% of the benchmark
 - SLS, at 85.00% of the benchmark
 - SCI, at 88.62% of the benchmark
 - CES, at 131.11% of the benchmark
 - CHRP, at 129.38% of the benchmark
 - CHCBS, at 87.71% of the benchmark
 - Targeted Case Management (TCM), at 87.84% of the benchmark.

Conclusions (Cont.)

- Analyses suggest the following service rates were sufficient for member access and provider retention, but may not be appropriate for reimbursement of high-value services:
 - EMT, at 40.92% of the benchmark
 - NEMT, at 37.51% of the benchmark

Conclusions (Cont.)

- Analyses were inconclusive to determine if the following services rates were sufficient for member access and provider retention, and current rates may not support appropriate reimbursement for high-value services:
 - HCBS Waivers
 - CMHS, at 80.42% of the benchmark
 - EBD, at 95.22% of the benchmark
 - CLLI, at 106.17% of the benchmark

Themes

- While member access and provider retention may not be affected by rates, rates may not be set appropriately for provision of high-value services or optimal service provision.
- Rates for similar services sometimes vary across different waivers, which accounts for differences in rate comparison benchmarking results.



Committee Questions



Stakeholder Comments





Committee Discussion

Department Working Recommendations

- Rate Review Recommendation Development
- Transportation Working Recommendations
- HCBS Waivers & Waiver Services Working Recommendations
- TCM Working Recommendations



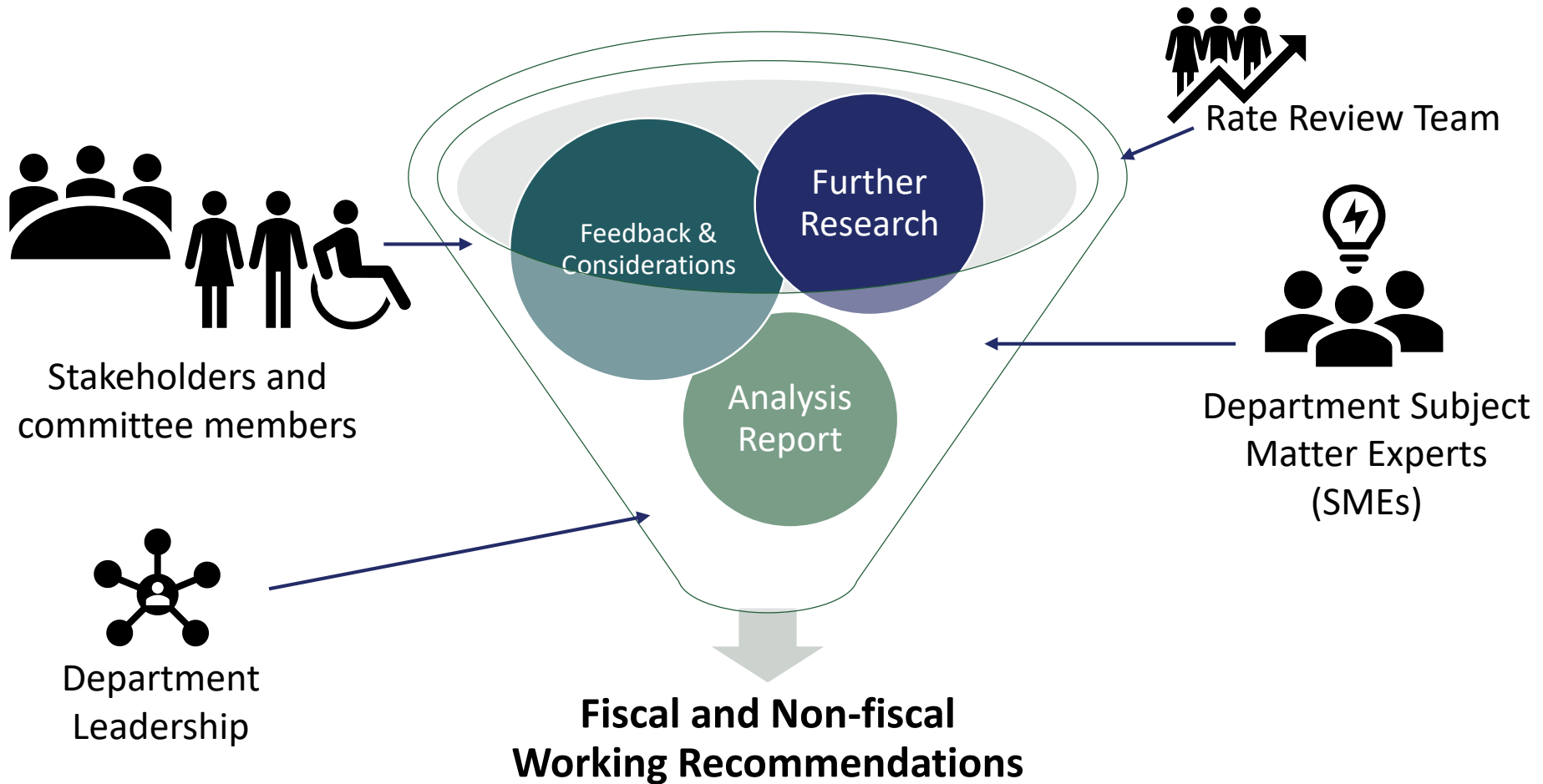
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Recommendations

- Recommendations include fiscal and non-fiscal approaches and are evidence-based
- Feedback received during this meeting will be documented, evaluated by the Department, and used to further refine the Department's recommendations that will be presented in the August meeting.

How are the Department's working recommendations developed?



Key Considerations

- The Department must evaluate a multitude of factors, including (but not limited to):
 - regulatory compliance,
 - clinical standards and best practices,
 - access to care,
 - federal and state authority,
 - budgetary authority
- Recommendations must be approved by Department leadership, OSPB, JBC, and frequently CMS
- As a result, some recommendations may receive full or partial approval later in the process, but may have potential for approval in later years as opportunities change

Rate Review Recommendation Considerations



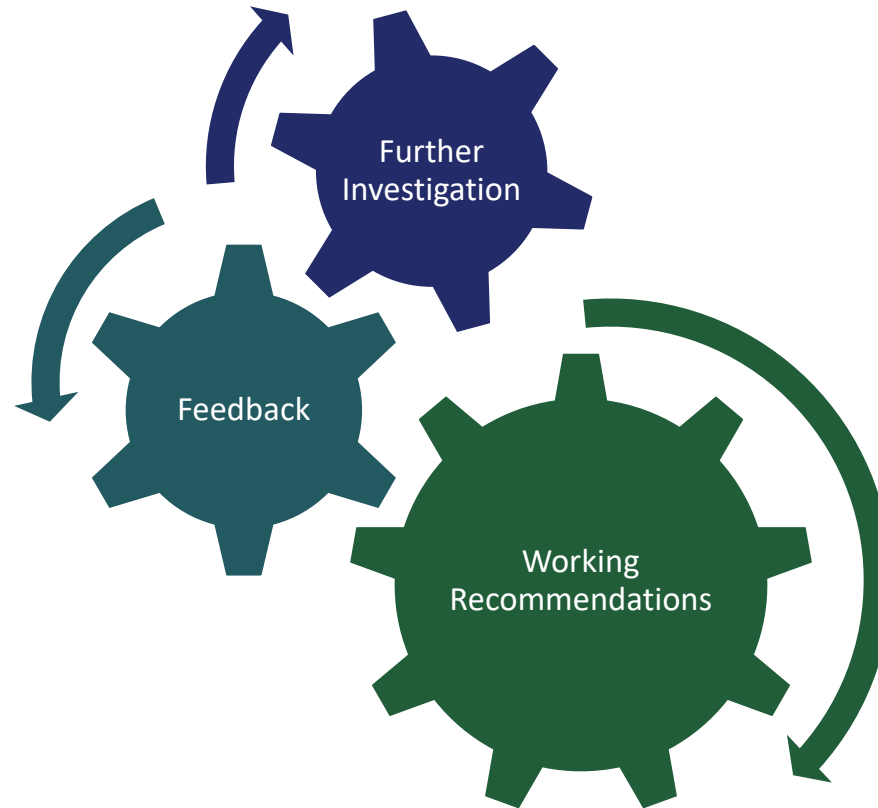
Equity across all services

Objective,
Evidence-Based
Process



Long-term
Objectives

How are Department Recommendations refined?



Comments & Feedback

Within Scope:

- Evidence-based feedback on Department fiscal and non-fiscal working recommendations

Out of Scope:

- The Department's budget process
- Requests for rate changes for services that are not under review in Year One

MPRRAC Guiding Principles

- Do not reinvent the wheel (e.g., if an established rate structure exists, consider using it).
- Support recommendations that work towards providing services in the least restrictive and most cost-effective environment.
- Develop methodologies to address geographic differences.
- Strive to reimburse for costs of hard goods.

Transportation Services

- Emergency Medical Transportation (EMT)
- Non-Emergent Medical Transportation (NEMT)



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Emergency Medical Transportation (EMT)

- Analysis Report Conclusion
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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EMT Recommendations

Analysis Report Conclusions

Analysis suggest EMT service rates at 40.92% of the benchmark were sufficient for access to care and provider retention; may not be appropriate for reimbursement of high-value services.

Considerations

Requirements for Emergency Vehicles

Access may not be directly impacted by rates

One of the lowest service rates reviewed in RRP

The Department Recommends:

Evaluating the authority to develop and implement an EMS treat-in-place model .

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

Increasing EMT service rates to 80% of the benchmark.

Non-Emergent Medical Transportation (NEMT)

- Analysis Report Conclusion
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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NEMT Recommendations

Analysis Report Conclusions

Analysis suggest NEMT service rates at 37.51% of the benchmark were sufficient for access to care and provider retention; may not be appropriate for reimbursement of high-value services.

Considerations

One of the lowest service rates reviewed in RRP

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

NEMT services may have been impacted by the COVID-19 pandemic and further impacted by increasing use of telemedicine services.

The Department Recommends:

Increasing NEMT service rates to 80% of the benchmark.

Continuing to monitor transportation claims and utilization data to identify trends related to the COVID-19 pandemic, and the impact, if any, on access to care and provider retention.



Committee Questions



Stakeholder Comments





Committee Discussion

Home and Community-Based Services (HCBS) Waivers

- Adult Waivers
- Children's Waivers
- Aggregate Waivers & Waiver Services



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Adult Waivers

- Analysis Report Conclusions
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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Analysis Report Conclusions - Adult HCBS Waivers

- Analyses suggest the following service payments were sufficient to allow for member access and provider retention:
 - BI payments at 116.80% of the benchmark
 - DD, at 103.81% of the benchmark
 - SLS, at 85.00% of the benchmark
 - SCI payments at 88.62% of the benchmark
- Analyses were inconclusive for the following service payments to determine if payments were sufficient to allow for member access and provider retention:
 - CMHS, at 80.42% of the benchmark
 - EBD, at 95.22% of the benchmark

Adult Waiver Recommendations

Analysis Report Conclusions

Analyses are insufficient to determine if ACF rates at 74.14% of the benchmark were sufficient for member access and provider retention. The Department is currently investigating TLP rate setting methodology to identify opportunities for improving access to care and provider retention.

Considerations

TLP services are unique and provide highly acute levels of care; Colorado provides a variety of different TLP services that are not provided by other states.

ACF per diem rates are much lower than other similar levels of assisted living facility-based care provided under Health First Colorado HCBS waivers

The Department Recommends:

Seeking authority to implement the results of a recent Transitional Living Program (TLP) rate setting project.

Evaluation of tiered rate reimbursement development for Alternative Care Facilities (ACFs) to support higher need members in the community.

Children's Waivers

- Analysis Report Conclusions
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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Children's Waiver Recommendations

Analysis Report Conclusions

Analyses suggest the following service payments were sufficient to allow for member access and provider retention:

CES payments at 131.11% of the benchmark

CHRP, at 129.38% of the benchmark

CHCBS, at 87.71% of the benchmark

Analyses were inconclusive to determine if CLLI payments at 106.17% of the benchmark were sufficient to allow for member access and provider retention.

Considerations

CHRP foster home rates and respite service limits do not align with similar services on other waivers.

Limited capacity reported for residential services available to members ages 18 and under.

The Department Recommends:

Further increasing the CHRP foster care home rates to align with DD waiver host home rates.

Aligning respite service limits provided under the CHRP waiver with respite service limits under the CES Waiver.

Adding host homes as a residential provider type for members ages 18 and under to increase facility capacity limits and provider capacity.

Aggregate Waivers & Waiver Services

- Analysis Report Conclusions
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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Aggregate Waivers & Waiver Services Recommendations

Analysis Report Conclusions

Analyses indicate that aggregate HCBS waiver services were 97.7% of the benchmark. Individual rate ratios ranged from 34.37%-351.23%

Considerations

Various rates for similar services spanning multiple waivers and different geographical regions

In-home respite is not available under the CMHS waiver, unlike other adult waivers.

Respite services rates under the CLLI waiver are higher than on other waivers

The Department Recommends:

Aligning rates for services that span multiple waivers.

Pursuing the implementation of geographic rate modifiers for waiver services to address disparities of provider capacity across the state.

Further investigation of respite services, including provider capacity and retention, and access to respite services across populations.

Aggregate Waivers & Waiver Services Recommendations (Cont.)

Analysis Report Results

Personal Care (106.32%) and IHSS (105.64%)
 Homemaker – basic & enhanced (115.79%) and IHSS (105.64%)
 IHSS Health Maintenance Activities (86.67%)
 Day Habilitation (79.56%); Adult Day (84.82%); ACF per diem (73.14%)
 IRSS/GRSS (110.68%)

Considerations

Provider agencies of personal care and homemaker services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.

Adult day rates are reportedly too low to continue providing the current level of care to Medicaid members

Providers report current rate is too low to provide individualized supports for IRSS.

The Department Recommends a minimum of a 10% rate increase to the following services:

Personal Care (IHSS), Homemaker (basic, enhanced, IHSS), IHSS HMA, and CDASS

Day Habilitation, Adult Day, and ACF per diem rate

Individual and Group Residential Support Services (IRSS/GRSS)





Committee Questions



Stakeholder Comments





Committee Discussion



Target Case Management (TCM)

- Analysis Report Conclusion
- Key Considerations
- Working Recommendations
- Committee Questions
- Stakeholder Comments
- Committee Discussion



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TCM Recommendations

Report Conclusion

Analyses suggest TCM service rates at 87.84% of the benchmark were sufficient to allow for member access and provider retention.

Considerations

Benefits of conflict-free case management.

The Department is dedicated to compliance with federal and state regulations regarding conflict-free case management.

The Department Recommends:

Continuing support to the Case Management Redesign project to ensure evidence-based data and stakeholder perspectives inform project initiatives.



Committee Questions



Stakeholder Comments





Committee Discussion

Next Steps & Announcements

- Next public meeting: August 27, 2021, from 9:00 a.m. - 12:00 p.m.
 - Primary Purpose: Review refined recommendations proposed by the Department; allow time for stakeholder and committee comments
 - Secondary Purpose: Annual MPRRAC Member Training (required by HB19-1198)



Questions?



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Thank you!

