COLORADO
Department of Health Care Policy & Financing

June 19, 2020

RATE REVIEW WORKING RECOMMENDATIONS

PEDIATRIC PERSONAL CARE (PPC)

ANALYSIS RESULTS

- Analyses suggest that PPC payments at 134.35% of the benchmark were sufficient to allow for member access and provider retention.[1]
- Colorado as a percentage of five other states' Medicaid rates ranged from 109.48%-140.57%.[2]

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- There is a reportedly low availability of active providers of PPC services for Medicaid members.
- Low wages are paid to PPC caregivers.

ADDITIONAL CONSIDERATIONS

- PPC services are performed by a non-medically trained caregiver in the member's home.
- Members seeking PPC services are often directed by home health agencies to Long-Term Home Health (LTHH) services provided by licensed home health agencies.
- PPC service rates were compared to an average of other states' Medicaid rates; Colorado, Florida, and Texas are the only states that reimburse for pediatric-specific personal care services.
- The total number of billing providers does not represent the total number of caregivers employed by agencies providing PPC services.
- Provider billing locations do not encompass all brick-and-mortar agency locations.

WORKING RECOMMENDATIONS

- The Department recommends continuing outreach efforts to Home and Community-Based Services (HCBS) class B licensed providers to alert them that PPC state plan services is allowable and billable by license type.

[1] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[2] States used in the PPC rate comparison analysis were California, Florida, Idaho, Louisiana, and Texas.

HOME HEALTH

ANALYSIS RESULTS

- Analyses suggest home health payments at 101.72% of the benchmark were sufficient to allow for member access and provider retention.[3]
- The individual rate ratios were 76.04%-348.53% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- If more home health caregivers were available, more members could leave the hospital setting earlier.
- The home health fixed rate does not have a minimum requirement for services.

ADDITIONAL CONSIDERATIONS

- Unit values vary from state-to-state; Colorado visits are either one hour or two and a half hours per visit, compared to other states that reimbursed based on various unit values (e.g., 15-minute increments, untimed visits, etc.).
- Colorado is one of four states[4] both a home health basic and extended rate.
    - The rate comparison shows that Colorado Medicaid pays $38.12 for the home health basic rate, which is for the initial one-hour visit; this rate is 76.04% of the benchmark average.
    - Colorado Medicaid balances out the lower basic rate with additional reimbursement for visits lasting more than one-hour with the home health extended rate, which pays an additional $11.39 for each extended unit of 15-30 minutes; this rate is 348.53% of the benchmark.
- Electronic Visit Verification (EVV) is now live; EVV will be tied to claims starting in January 2021 and data will be available for future years of review. It should be noted that there will be a live-in caregiver exemption, which may limit the data the Department receives from EVV.
- The Department received information that some home health agencies merged with other agencies, which led to a perceived decrease in active providers, but did not have an impact on the actual number of agencies providing home health services; therefore, access was not negatively impacted.
- Total number of billing providers does not represent the total number of caregivers employed by home health agencies.
- Provider billing locations do not encompass all brick-and-mortar agency locations.

[3] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[4] Other states that include both basic and extended home health rates on their fee schedules are Louisiana, Nebraska, and Ohio.

- Home health services received 1% across-the-board (ATB) rate increases in July 2018 and July 2019.
- In 2017, the following home health services received a Targeted Rate Increase (TRI) of 6.01-6.02%:
    - Registered Nurse (RN)
    - Occupational Therapy
    - Physical Therapy
    - Speech Therapy

WORKING RECOMMENDATIONS

- The Department recommends further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health speech therapy rates and outpatient speech therapy rates).
- The Department recommends further evaluating the development, implementation, and operationalizing minimum duration requirement(s) for home health visits.

PRIVATE DUTY NURSING (PDN)

- Analyses suggest that PDN service payments at 98.15% of the benchmark were sufficient to allow for member access and provider retention.[5]
- Individual rate ratios ranged from 74.08%-102.03% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Licensed Practical Nurse (LPN) rates are too low to be competitive; concerns were raised regarding untapped potential in recruiting LPNs for PDN providers servicing Colorado Medicaid members.

ADDITIONAL CONSIDERATIONS

- LPN rate received a 7.24% TRI in 2017; data from before and after the TRI showed utilization was unaffected.
- The Department's rate setting process considers operational costs, which includes costs such as staff wages, benefits, rental and utility costs, etc. Cost reporting, which is not available to the Department, would further inform rate setting efforts; however, the Department has not been offered these reports.
- Individually, the LPN rate is 96.98% of other states' average Medicaid rate and the RN rate is 102.03% of other states' average Medicaid rate.
- Unit values for PDN services in Colorado are based on one hour per visit, compared to other states that reimburse based on various unit values (e.g., 15-minute increments, untimed visits, etc.).
- Total number of billing providers does not represent the total number of caregivers employed by agencies providing PDN services.
- Provider billing locations do not encompass all brick-and-mortar agency locations.

WORKING RECOMMENDATIONS

- The Department recommends further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health RN/LPN rates and PDN RN/LPN rates).

[5] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.

PEDIATRIC BEHAVIORAL THERAPY (PBT)

ANALYSIS RESULTS

- Analyses suggest that PBT payments at 92.90% of the benchmark were sufficient to allow for member access and provider retention.[6]
- Individual PBT rate ratios ranged from 85.99%-94.31% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The impact of transitioning PBT from a waiver service to an EPSDT service was a perceived rate cut for providers.
- The increased complexity of requirements for EPSDT providers is impacting provider retention.
- There is a disruption of services when members reach age 21 because they must transition from EPSDT services to waiver services.

ADDITIONAL CONSIDERATIONS

- The reimbursement rates for PBT services remained consistent in the transition from waiver to EPSDT services.
- There are currently 431 providers now rendering PBT services, compared to only 88 providers that were enrolled as Behavioral Services providers through the Children's Extensive Supports (CES) and Children with Autism (CWA) waivers.
- Colorado is currently the only state offering pediatric-specific rates for behavioral therapy.
- There are no additional requirements necessary for enrolled providers to provide EPSDT services.
- Prior Authorization Request (PAR) processes are similar across services that require PARs.
- Members should work with the Case Management Agency (CMA) to transition services when approaching 21 years of age.

WORKING RECOMMENDATIONS

- The Department recommends evaluating seeking federal approval to make PBT a State Plan benefit.
- The Department recommends continuing to support internal efforts to recruit and retain providers of PBT services and promote access to care.

[6] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.

SPEECH THERAPY

ANALYSIS RESULTS

- Analyses are inconclusive to determine if Speech therapy payments at 73.51% of the benchmark were sufficient to allow for member access and provider retention.[7]
- Speech Therapy individual rate ratios ranged from 16.82%-107.20% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Speech Therapy rates are not sufficient to offer competitive staff wages, retain specialized providers, or cover overhead and administration costs.
- Rates are significantly lower than home health speech therapy rates, even though both provider groups require similar levels of training and expertise.
- The feeding therapy rate is very low.

ADDITIONAL CONSIDERATIONS

- Utilization trends in data indicate migration of services from individual providers to home health agencies, who provide a wider range of services for individuals needing more comprehensive home health care.
- Home health agencies have more requirements and administrative costs compared to individual providers, which are factored into home health rates.
- Most therapy service visits include provision of more than one service.
- Speech therapy rates could not be rebalanced in a budget-neutral manner as previously recommended in the 2017 Medicaid Provider Rate Review Recommendation Report; rebalancing would have required additional funds. [8]

WORKING RECOMMENDATIONS

- The Department recommends rebalancing speech therapy rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change. [9]
- The Department recommends further evaluating whether initiating a rate setting project to create more equity across similar services would be beneficial (e.g., consider home health speech therapy rates and outpatient speech therapy rates).

---

[7] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[8] The Department did not request funding in the 2018 Long Bill to rebalance speech therapy rates, but the rates could not be rebalanced without impacting the budget.
[9] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

PHYSICAL AND OCCUPATIONAL THERAPY (PT/OT)

ANALYSIS RESULTS

- Analyses suggest PT/OT payments at 86.41% of the benchmark were sufficient to allow for member access and provider retention.[10]
- PT/OT individual rate ratios ranged from 28.06%-793.16% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Department did not receive any feedback from stakeholders regarding PT/OT services or rates.

ADDITIONAL CONSIDERATIONS

- Most visits for therapy services include provision of more than one service.

WORKING RECOMMENDATIONS

- The Department recommends rebalancing PT/OT rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[11]

[10] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[11] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

PROSTHETICS, ORTHOTICS, AND SUPPLIES (POS)

ANALYSIS RESULTS

- Analyses suggest that POS payments at 80.80% of the benchmark were sufficient to allow for member access and provider retention.[12]
- Individual rate ratios ranged from 4.46%-1,233.91% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Department did not receive any feedback from stakeholders regarding POS services or rates.

ADDITIONAL CONSIDERATIONS

- Data analyses did not include out-of-state claims including those from border towns and mail-order utilization.

WORKING RECOMMENDATIONS

- The Department recommends rebalancing POS rates and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[13]

[12] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[13] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

VISION

ANALYSIS RESULTS

- Analyses suggest that vision payments at 81.13% of the benchmark were sufficient to allow for member access and provider retention.[14]
- Individual rate ratios ranged from 25.06%-190.56% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Department did not receive any feedback from stakeholders regarding vision services or rates.

ADDITIONAL CONSIDERATIONS

- The Department did not have any feedback regarding vision services or rates.

WORKING RECOMMENDATIONS

- The Department recommends rebalancing vision rates and will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[15]

[14] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.

[15] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonable consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.