COLORADO
Department of Health Care Policy & Financing

September 18, 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

- The PPC benefit only refers to State Plan Pediatric Personal Care services for members under the age of 20 that qualify for one of 17 personal care tasks.[3]
- 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 are allowable and billable by license type.

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[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.
[3] See the Pediatric Personal Care Services web page for a list of the 17 personal care tasks. The PPC benefit does not include personal care services provided through Home and Community-Based Services (HCBS) Waivers; see the Home and Community-Based Services web page for more information. HCBS waiver services are scheduled to be reviewed in 2021; for more information, see the Updated Rate Review Process Five-Year Schedule.

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.[4]
- 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.
- Agencies are having difficulty hiring caregivers; providers suggest the current rate is the reason.
- Aligning with Medicare is insufficient due to the short-term nature of Medicare Home Health services.
- Rates should be set at 90% of the Medicare Low Utilization Payment Adjustment (LUPA) rates for home health services.
- Electronic Visit Verification (EVV) requirements will discourage smaller providers from delivering Home Health 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[5] with 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.[6]

[4] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[5] Other states that include both basic and extended home health rates on their fee schedules are Louisiana, Nebraska, and Ohio.
[6] This payment methodology suggests Colorado Medicaid reimburses more accurately based on the length of the visit, compared to other states that only pay a basic rate for a visit of any length.

- A previous assessment by the Department concluded that LUPA is not an appropriate comparator for home health rates due to differences in client eligibility, utilizer characteristics, and unit designations.[7]
- The Joint Budget Committee (JBC) allocated funding to the Department to bring rates to 30% of Medicare LUPA, stating that funding would be provided in the following two years to bring rates to 60% and then 90% of Medicare LUPA rates. However, the Department only received funding for the first year.
- EVV is a federal requirement; the Department has worked closely with stakeholders to ensure the option of a state system that meets the needs of providers and members, while also complying to the requirements established by the Centers for Medicare and Medicaid (CMS).
- 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.
- 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.

[7] See page 14-15 of the 2016 Medicaid Provider Rate Review Recommendation Report for more information.

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.[8]
- 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.
- Data used in the rate comparison was outdated.

ADDITIONAL CONSIDERATIONS

- Rate comparison data for the 2020 Medicaid Provider Rate Review Analysis Report uses claims information from FY 2018-19 to determine accurate utilization levels and estimate expenditures; however, data is repriced using the most recently available fee schedules (e.g., July 2019 or January 2020).[9]
- 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.
- LPN rates for different settings, such as hospitals, are based on numerous factors including, but not limited to, job complexity and average patient load.
- 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 unit, 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

[8] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[9] See Appendix B of the 2020 Medicaid Provider Rate Review Analysis Report for more information.

- 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).

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.[10]
- 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.

[10] 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.[11]
- 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. [12]

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. [13]
- 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).

[11] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[12] 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.
[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.

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.[14]
- PT/OT individual rate ratios ranged from 28.06%-793.16% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Physical Therapy Association of Colorado has been trying to get a rate increase directly through the JBC for several years.
- Providers are unwilling to accept Medicaid patients because the rates are too low.
- The increase usage of telemedicine visits during the pandemic has had a positive impact on PT/OT.

ADDITIONAL CONSIDERATIONS

- Data shows utilization, rendering providers, and expenditures are increasing for PT/OT services, suggesting PT/OT providers are willing to accept Medicaid patients.[15]
- 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.[16]

[14] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[15] See the 2020 Medicaid Provider Rate Review Analysis Report for more information; the Department acknowledges there may be other opportunities to improve access to care and provider retention.
[16] 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.[17]
- Individual rate ratios ranged from 4.46%-1,233.91% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Several supplies, especially those for pediatric patients, are not covered by Medicare, due to the difference in populations served by Medicare.
- Providers request an increase to at least 80% of Medicare rates, and 90% would be preferred.

ADDITIONAL CONSIDERATIONS

- Medicare was the primary payor used for the rate comparison analysis; where a Medicare comparison was unavailable, the rate was compared with other states' Medicaid rates.
    - Medicare rates for supplies are comparable due to the nature of the benefit.
    - The rates compared to other states' Medicaid rates provide insight to how we compare on reimbursement for supplies that are not covered by Medicare.
- 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.[18]

[17] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[18] 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.[19]
- Individual rate ratios ranged from 25.06%-190.56% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- There was a large increase in provider enrollment for vision services following a rate increase five years ago; for this reason, a decrease in rates could have a negative impact on provider retention.

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.[20]

GENERAL

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Current climate and rate changes; some services should still be considered for rate increases (e.g., PDN).
- Benchmark when comparing to other states' Medicaid rates should be 100%, not 80% to 100% of the rate.

ADDITIONAL CONSIDERATIONS

- Ultimately, the JBC, in working with the Department, is responsible for next fiscal year's budget; while we can make recommendations, it is ultimately not up to us; stakeholder concerns will be

[19] See the 2020 Medicaid Provider Rate Review Analysis Report for more information.
[20] 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.

documented in the 2020 Medicaid Rate Review Recommendation Report that the JBC receives on November 1, 2020.
    - The Rate Review Team is working with other teams across the Department to minimize the impact of COVID-19-related rate changes across all services.
- The Department does not agree that all services that are compared to other states' Medicaid rates should be set to 100% of the benchmark; but that it identifies the need for additional evaluation to determine the appropriate rate. The following should also be considered:
    - Rate setting projects that evaluate all factors that impact Colorado Medicaid providers.
    - The benchmark is an average of other states' rates, not a single rate, which means the average can be impacted by outliers that distort the data.
    - While comparing to an average provides an overall picture of how we compare to other Medicaid programs, there are often other factors that impact Medicaid rates that must be considered, such as:
        - state-specific initiatives;
        - population size, density, and demography;
        - geography;
        - state budgets/funding availability; and
        - wages/standard of living.