2021 MEDICAID PROVIDER RATE REVIEW PROCESS: WORKING RECOMMENDATIONS

EMERGENCY MEDICAL TRANSPORTATION (EMT)

ANALYSIS RESULTS[1]

- Analyses suggest that EMT payments at 40.92% of the benchmark were sufficient to allow for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[2]
- Individual rate ratios were 29.44%-99.51%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- EMT rates are among the lowest for service groupings reviewed through the Medicaid Provider Rate Review Process.
- EMT services have a high readiness cost compared to other services due to the requirements that emergency vehicles be staffed with trained service delivery providers and stocked with any medical equipment that may be required.
- There have been small incremental rate increases for particular EMT services, but not any noticeable, significant increases in reimbursement.
- Providers appreciate collaboration with Department on policies and the supplemental payment program since 2016 but indicate there are still gaps in reimbursement for EMT service providers.

ADDITIONAL CONSIDERATIONS

- Since EMT services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report, both total members accessing EMT services and total active EMS providers increased. In addition, total expenditures increased by over $12 million;[3]
- As a result of the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of EMT services, effective July 2017;[4]
- Effective January 1, 2018, the Department amended the Colorado State Plan to create an EMT Supplemental Payment program that allows eligible EMS providers to receive an annual supplemental payment for the uncompensated costs incurred by providing ground or air emergency medical transportation services to Medicaid beneficiaries. Data indicates the supplemental payment program provided 43 participating providers with $11 million in

[1] These results are only based on the results of the 2021 Medicaid Provider Rate Review Analysis Report and do not speak to services whose rates were excluded according to the rate comparison methodology outlined in Appendix B of the 2021 Medicaid Provider Rate Review Analysis Report.
[2] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.
[3] For more information, see the 2016 Medicaid Provider Rate Review Analysis Report.
[4] EMT services received a Targeted Rate Increase (TRI) of 6.61%, effective July 2018.

supplemental reimbursement in FY 2017-18, and provided 63 providers with $26 million in supplemental reimbursement in FY 2018-19;[5]

- The total number of active providers does not represent the total number of service delivery providers employed by agencies providing EMT services.

WORKING RECOMMENDATIONS

- The Department recommends increasing EMT services rates to 80% of the benchmark.[6]
- The Department recommends evaluating the authority to develop and implement an EMS treat-in-place model.[7]
- The Department recommends continuing to pursue opportunities for policy development, working with community partners to understand current practices and community needs.[8]

[5] For more information, see the Public Emergency Medical Services Supplemental Payment web page.
[6] Rate changes will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022. The Department will consider completing this recommendation in alignment with future budget requests.
[7] This recommendation may require additional resources, such as future budget requests.
[8] The Department is currently investigating opportunities for Emergency Medical Services (EMS) to support community needs.

NON-EMERGENT MEDICAL TRANSPORTATION (NEMT)

ANALYSIS RESULTS[9]

- Analyses suggest NEMT payments at 37.51% of the benchmark were sufficient to allow for member access and provider retention; however current rates may not support appropriate reimbursement for high-value services.[10]
- NEMT individual rate ratios ranged from 27.06%-134.51%.[11]

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

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

DEPARTMENT FEEDBACK

- Both total members accessing NEMT services and total active NEMT providers increased since these services were reviewed in the 2016 Medicaid Provider Rate Review Analysis Report. In addition, total expenditures increased by over $40 million;[12]
- The average penetration rate for four counties (Moffat, Routt, Jackson, and Rio Blanco) significantly increased from below the state average in FY 2014-15 to above the state average in CY 2019.[13]
- As a result of the rate review team working with the Governor's Office in response to the 2016 Medicaid Provider Rate Review Recommendation Report, the legislature approved Targeted Rate Increases (TRIs) to a subset of NEMT services, effective July 2017;[14]
- NEMT providers are provided a brokerage fee by the Department, which is subject to contracted value-based obligations that may impact total fee reimbursed to the provider;[15]
- Many Medicaid recipients in rural areas are already vehicle-dependent due to the lack of public transportation infrastructure, which may impact use of NEMT services in those regions;
- Data, collected after the CY 2019 base data, suggests transportation services may have been disproportionately impacted by the COVID-19 pandemic, and further impacted by the evolving and increasing use of telemedicine services;[16] and

[9] These results are only based on the results of the 2021 Medicaid Provider Rate Review Analysis Report and do not speak to services whose rates were excluded according to the rate comparison methodology outlined in Appendix B of the 2021 Medicaid Provider Rate Review Analysis Report.
[10] The Department recognizes that, while rates are sufficient, there may be other opportunities to improve access to care and provider retention.
[11] Individual rate ratios for each procedure code are contained in Appendix B of the 2021 Medicaid Provider Rate Review Analysis Report.
[12] Total member count, provider count, and paid dollars from the 2016 Medicaid Provider Rate Review Analysis Report is based on claims data from FY 2014-15, which does not include expenditures from July 2014- November 2014 because the previous broker did not submit claims into the MMIS.
[13] Penetration rate averaged 0.9 in these four counties in FY 2014-15 and 5.88 in CY 2019.
[14] NEMT services also received a TRI of 6.61%, effective July 2018.
[15] For more information, see the NEMT web page.
[16] For more information, see Appendix J in the 2021 Medicaid Provider Rate Review Analysis Report.

- The total number of billing providers does not represent the total number of service delivery providers employed by agencies providing NEMT services.

WORKING RECOMMENDATIONS

- The Department recommends increasing NEMT services rates to 80% of the benchmark.[17]
- The Department recommends 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.[18]

[17] Rate changes will be implemented upon state and federal approval, with a projected implementation date of July 1, 2022; the Department will consider completing this recommendation in alignment with future budget requests.
[18] The Department is currently collecting this data and will monitor for up to a minimum of 24 months, at which point the Department will evaluate the need to continue monitoring transportation data.

ADULT WAIVERS

ANALYSIS RESULTS[19]

- Analyses suggest that BI payments at 116.80% of the benchmark were sufficient to allow for member access and provider retention.[20]
- Analyses suggest that DD payments at 103.81% of the benchmark were sufficient to allow for member access and provider retention.
- Analyses suggest that SLS payments at 85.00% of the benchmark were sufficient to allow for member access and provider retention.
- Analyses are inconclusive to determine if CMHS payments at 80.42% of the benchmark were sufficient to allow for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[21]
- Analyses are inconclusive to determine if EBD payments at 95.22% of the benchmark were sufficient to allow for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[22]
- Analyses suggest that SCI payments at 88.62% of the benchmark were sufficient to allow for member access and provider retention.
- Individual rate ratios ranged from 35.07%-351.23%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Transitional Living Program (TLP) services are offered by a limited number of providers since they are unable to provide the level of care necessary for the current reimbursement rate, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services
- Provider agencies of personal care services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.
- Provider agencies of personal care services in rural areas also expressed concerns regarding the discrepancies between rural rates and Denver County rates.
- Mental health counseling under the BI waiver has a reportedly low number of providers, which may indicate a potential access to care issue for members enrolled on the BI waiver needing these services.
- Adult day rates are reportedly too low to continue providing the current level of care to Medicaid members.

[19] These results are only based on the results of the 2021 Medicaid Provider Rate Review Analysis Report and do not speak to services whose rates were excluded according to the rate comparison methodology outlined in Appendix C of the 2021 Medicaid Provider Rate Review Analysis Report.
[20] The Department recognizes that, while rates may be sufficient for member access and provider retention, there may still be opportunities to improve member access and provider retention, as well as opportunities to address quality of care and appropriate reimbursement of high-value services.
[21] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.
[22] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.

- HCBS Final Rule established new requirements that increased administrative burden on providers of adult day services, yet the rate was not changed to reflect the added time and resources to complete these requirements.[23]
- Unit limits for behavioral services are reportedly too low to provide frequency of care preferred by providers and utilizers of these services.
- Job development services under the supported employment service grouping have low rates and working with Division of Vocation Rehabilitation (DVR) to receive adequate reimbursement for these services is confusing.[24]
- Additional procedure code for individualized day habilitation services and the addition of virtual service delivery methods are expected to increase member access to these services; and
- Some providers are concerned requirements for residential habilitation due to rule changes made in 2019 regarding Individual Residential Supports and Services (IRSS) settings will impact provider retention since the current rate may not be set at an adequate rate to provide individualized supports.
- There are reportedly significant access issues in rural and frontier counties for ACF, adult day, and respite services provided under the CMHS waiver.
- Provider agencies of personal care services in rural areas expressed concerns regarding acquisition and retention of staff due to reportedly low reimbursement rates.
- ACF per diem rates are much lower than other similar levels of assisted living facility-based care provided under Health First Colorado HCBS waivers (e.g., nursing facilities).
- Stakeholders expressed desire for number of hours for which in-home respite can be provider be increased; there is currently a 6.5-hour per day maximum for in-home respite services.
- Stakeholders also indicate that the pay structure for in-home respite services incentivizes facility-based care, such as in an ACF or nursing facility.
- Providers expressed concerns regarding current rates and the impact the minimum wage legislation pass-through will have on their ability to cover cost of service provision through Medicaid reimbursement alone.[25]
- There is a reported lack of providers Complementary & Integrative Health Services (i.e., professional therapy services including acupuncture, chiropractic, and massage therapy services on the SCI waiver) grouping on the SCI waiver.
- Stakeholders note that massage therapy services under the SCI waiver are reimbursed at a lower rate than massage therapy services reimbursed under other waivers.[26]

ADDITIONAL CONSIDERATIONS

- In September 2020, an additional procedure code was added to adult day services on the BI waiver to provide a billable 15-minute unit.
- As of January 2020, the unit for the Independent Life Skills Training (ISLT) reimbursement rate changed from a 1-hour unit to a 15-minute unit.
- The Department is working with providers to identify opportunities for improving access to care to TLP services.
- There has been an increase in total adjusted expenditures, total utilizers, and providers since BI services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report;

[23] For more information on the HCBS Final Rule, see the HCBS Settings Final Rule web page.
[24] DVR is the primary payer for these services; Colorado Medicaid will only cover these services if they are not covered by DVR.
[25] This feedback refers to SB19-238, which was signed into law in 2019 with a wage pass-through for IHSS personal care and homemaker services.
[26] For detailed HCBS waivers rate information, see the Health First Colorado Fee Schedule.

- BI providers and utilizers increased by over 4% between CY 2018 and CY 2019.
- BI services are sometimes provided by parent or family Certified Nursing Aids (CNAs) or relative caregivers.
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS), which will require agencies providing personal care and homemaker services to pass an increase in rates directly through direct care workers;[27]
- Transitional Living Program (TLP) is highly specialized and reimburses based on levels of complexity; other states' Medicaid programs do not have a service that fully encompasses totality of services provided through Colorado's HCBS Transitional Living Program.
- The Department is currently investigating rate setting methodology for TLP services.
- Day treatment services were not utilized in CY 2019 and there were no providers of day treatment services for Colorado Medicaid; the cause of this is not clear and the Department is continuing to investigate whether these services are accessed under other waivers, if there is no need for these services for members enrolled on the BI waiver, the benefit is too confusing for providers, the service could benefit from a rate change, among other factors.
- Continued efforts are being made to increase the availability of providers in the Front Range and rural areas.
- In 2017, prevocational services at 39.22%-162.12% of the benchmark were flagged as an area where there may be access to care issues; analyses reveal that prevocational services on the DD waiver have increased to 48.94%-195.52% of the benchmark. Additionally, specialized habilitation services have become the preferential method for providing these types of services.[28]
- A new procedure code was temporarily added for specialized day habilitation to provide one-on-one individualized service; the Department is investigating if this service should be permanently added to day habilitation services.
- Several reimbursement rates for SLS waiver services vary for the same or similar services provided on other waivers.[29]
- Utilization has decreased on the CMHS waiver from CY 2018 to CY 2019; the Department is aware that utilization has been decreasing and is continuing to investigate the factors attributing to this decrease, whether they are unique to Medicaid, if there is a potential access to care issue, and if rates are attributable to those issues.
- Several reimbursement rates for CMHS waiver services vary for the same or similar services provided on other waivers.[30]
- The Department is investigating the possibility of merging the CMHS waiver with the EBD waiver, but has identified challenges due to the increasing utilization and popularity of IHSS health maintenance activities.
    - in addition, EBD includes IHSS and in-home respite services that are currently not available to members enrolled on the CMHS waiver; merging these waivers is expected to increase expenditures for these services.
- All services available through the CMHS waiver are also available through the EBD waiver, but IHSS and in-home respite are not available to members enrolled in the CMHS waiver.
    - anecdotal evidence indicates members may be preferential to receiving services through the EBD waiver.

[27] For more information, see SB19-238.
[28] This is in alignment with the statewide initiative to emphasize competitive integrated employment as an Employment First state.
[29] Some rates are in alignment with DD waiver services. See the Health First Colorado Fee Schedule for more details.
[30] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.

- In-home respite is not available on the CMHS waiver but is available on other adult waivers;
- There has been an overall increase in total adjusted expenditures, distinct utilizers, and active providers since the CMHS services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.[31]
- The total number of service provider locations does not represent the total number of caregivers or individual service delivery providers of CMHS services.
- EBD personal care and IHSS personal care services can be provided by a relative.
- Several reimbursement rates for EBD waiver services vary for the same or similar services provided on other waivers.[32]
- There has been an increase in total adjusted expenditures, distinct utilizers, and active providers since EBD waiver services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.
- ACF reimbursement rates received a 25% targeted rate increase (TRI), effective October 2018 as a result of the 2017 Medicaid Provider Rate Review Recommendation Report.[33]
- Some EBD services can be performed by family member.
- As of January 2021, the new Utilization Review/Utilization Management (UR/UM) contract with Telligen was initiated; this process includes a review of all Health Maintenance Activities (HMA) authorizations for appropriateness and to ensure there is no duplication of services.
- There has been an increase in total adjusted expenditures, total utilizers, and providers rendering services since the SCI services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.
- The waitlist for SCI ended in July 2015, attributing to the increase in utilizers, providers, and expenditures.
- SCI services are only available to members in the Denver Metro area.
- There is currently legislation proposed to expand the SCI waiver to members statewide; the Department is tracking this potential legislative change.[34]
- Due to reportedly limited provider availability for complimentary and integrative health services, the Department prioritized direct provider outreach to providers of complimentary and integrative health services[35] since 2018 to increase enrollment of SCI providers.
- The Department continues to prioritize efforts to increase provider availability for SCI services.
- A new location for complementary and integrative health services[36] under the SCI waiver (included under professional therapy services for the purposes of this report) was opened in January of 2019, leading to an increase in both utilizers and providers of those services.
- Cost reporting is needed to address wages, but stakeholders thus far have been hesitant to share cost reports.

[31] While there has been increases in these metrics since the CMHS waiver was previously reviewed, there was a decrease observed in total expenditures, utilizers, and providers from CY 2018 to CY 2019. The Department is aware of this decrease and continues to monitor and investigate the factors attributing to this decrease.
[32] Some rates are in alignment with other waiver services. See the Health First Colorado Fee Schedule for more details.
[33] See the July 2018 Provider Bulletin for more information.
[34] For more information, see SB21-038.
[35] Complementary & Integrative Health services include massage therapy, acupuncture, and chiropractic services; procedure-code level detail of services reviewed under each grouping is contained Appendix F in the 2021 Medicaid Provider Rate Review Analysis Report.
[36] Complimentary and integrative health services include massage therapy, acupuncture, and chiropractic services.

- The total number of billing providers does not represent the total number of direct service providers employed by provider agencies.

WORKING RECOMMENDATIONS

- The Department recommends seeking authority to implement the results of a recent Transitional Living Program (TLP) rate setting project.[37]
- The Department recommends evaluation of tiered rate reimbursement development for Alternative Care Facilities (ACFs) to support higher need members in the community.[38]

*Please note, recommendations that include services available on both adult and children's waivers, including the recommendation to increase multiple service rates, are shared in the Aggregate Waiver and Waiver Services section on page 12.

[37] The Department is currently working on this project; the Department is seeking state and federal authority to implement new TLP rate(s), with a projected implementation date of January 1, 2023 at the earliest. This recommendation may require further resources, such as future budget requests.
[38] See the APRA HCBS Funding Plan Overview for more information. Rate changes will be implemented upon state and federal approval. This recommendation may require additional resources, such as future budget requests.

CHILDREN'S WAIVERS

ANALYSIS RESULTS

- Analyses were inconclusive to determine if CLLI payments at 106.17% of the benchmark were sufficient to allow for member access and provider retention; current rates may not support appropriate reimbursement for high-value services.[39]
- Analyses suggest that CES payments at 131.11% of the benchmark were sufficient to allow for member access and provider retention.
- Analyses suggest that CHRP payments at 129.38% of the benchmark were sufficient to allow for member access and provider retention.
- Analyses suggest that CHCBS payments at 87.71% of the benchmark were sufficient to allow for member access and provider retention.
- Individual rate ratios ranged from 34.37%-307.81%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Provider agencies of homemaker services in rural areas expressed concerns regarding acquisition and retention of staff, due to reportedly low reimbursement rates.
- There is a reported lack of professional therapy services providers, particularly in rural and frontier counties; some feedback indicates that rates are too low for provider retention in counties where utilization is so low, which creates access issues for the members who do need CLLI, CHRP, and CES services in those counties. This is particularly notable for hippotherapy service providers.
- There is a reportedly low number of respite providers available for members enrolled in the CES waiver.

ADDITIONAL CONSIDERATIONS

- The Department has started allowing reimbursement for HCBS telehealth services and is working to implement HCBS telehealth services permanently, which is expected to increase access;[40]
- The Butterfly Program, a provider of several CLLI services, closed in late 2018, which led to a slight decrease in utilization; however, increases in active providers during this time indicate members' access to CLLI services was not significantly impacted by this closure; the Department will continue to monitor access to these services and whether decrease in active providers for palliative and supportive care services is a result of low need for these services or if an access issue may be present, if it is unique to Medicaid, and whether it is attributable to rates.
- The Department continues to prioritize efforts to increase provider availability for CLLI and CES services, especially rural and frontier counties (including the Front Range); and

[39] The Department is conducting additional research and will identify opportunities, if any, to improve access to care and provider retention.

[40] The Department was approved to provide HCBS telehealth services by CMS for the duration of the COVID-19 pandemic and is investigating the possibility of implementing permanent HCBS telehealth services. More information on the status of HCBS telehealth services can be found on the Office of Community Living (OCL) Stakeholder Engagement web page.

- The CLLI waiver has typically low utilization due to the nature of the population this waiver serves; low demand for services often results in lower numbers of providers rendering those services.
- Recent legislation to note includes SB19-238 wage pass-through for personal care and homemaker services (including IHSS services), which will ensure livable wages are paid to caregivers employed by agencies providing personal care and homemaker services; and
- Personal care services were removed from the CES waiver in 2015 and are now available to Health First Colorado members ages 0-20 through pediatric personal care services now offered as a State Plan benefit.[41]
- In January 2018, behavioral therapy services were removed from the CES and CHRP waivers and implemented as a benefit through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; this change has increased provider availability and member access to pediatric behavioral therapy services since 2018 and the Department is currently seeking federal approval to make pediatric behavioral therapy services a State Plan benefit;
- In January 2019, the requirement that limited eligibility and enrollment on the CHRP waiver to foster care or child welfare recipients was removed, allowing children to stay in the family home to receive services available through the CHRP waiver.
- Increases in utilization and active providers continued after January 2019 eligibility change once Community Center Boards (CCBs) gained a greater understanding of the changes and began enrolling more members and providers.
- In 2018, a new rule version instituted the new case management referral process, which clarified roles and responsibilities for all parties. In addition, the rules outlined documentation and monitoring requirements for agencies and case managers; case managers also began using the IHSS Care Plan Calculator, a tool to help identify service needs for members;
- In February 2021, the Department initiated the case management redesign for HCBS waivers, which refers to several initiatives that will help increase access to case management, as well as improving access to all long-term services and supports;[42] and
- There has been a significant increase in expenditures for CHCBS waiver services, driven by much higher utilization of IHSS health maintenance services; the Department is aware of this change and is continuing to monitor IHSS health maintenance utilization and pursuing further information on the causes driving this significant increase.
- The total number of billing providers does not represent the total number of direct service providers employed by provider agencies.

WORKING RECOMMENDATIONS

- The Department recommends further increasing the CHRP foster care home rates to align with DD waiver host home rates.[43]
- The Department recommends adding host homes as a residential provider type for members ages 18 and under to increase facility capacity limits and provider capacity.[44]

[41] Pediatric personal care services were reviewed in the 2020 Medicaid Provider Rate Review Analysis Report.
[42] For more information, see the Case Management Redesign web page.
[43] This recommendation will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023.
[44] This recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023 at the earliest. This recommendation may require additional resources, such as future budget requests.

- The Department recommends aligning respite service limits provided under the CHRP waiver with respite service limits under the CES waiver.[45]

[45] This recommendation will be implemented upon state and federal approval, with a projected implementation date of Spring 2023 at the earliest.

ALL HCBS WAIVERS AND WAIVER SERVICES

ANALYSIS RESULTS

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

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- ACF, HCBS residential, personal care, and homemaker service providers report that agencies are requiring financial support to ensure the viability of the direct care workforce and continuation of these home and community-based service.

ADDITIONAL CONSIDERATIONS

- The current state of the direct care workforce.[46]
- The total number of billing providers does not represent the total number of direct service providers employed by provider agencies.

WORKING RECOMMENDATIONS

- The Department recommends aligning rates for services that span multiple waivers.[47]
- The Department recommends pursuing the implementation of geographic rate modifiers for waiver services to address disparities of provider capacity across the state.[48]
- The Department recommends further investigation of respite services, including provider capacity and retention, and access to respite services across populations.[49]
- The Department recommends a minimum of a 10% rate increase to the following services:[50]
    - Individual Residential Support Services (IRSS);
    - Group Residential Support Services (GRSS);

[46] For more information, see Appendix H in the 2021 Medicaid Provider Rate Review Analysis Report.
[47] This will include bringing the massage rate on CLLI and SCI waivers to match the SLS rate, as well as address other services such as Non-Medical Transportation (NMT), which spans multiple waivers but is set at different rates across waivers. This recommendation may require additional resources, such as future budget requests. These will be implemented upon state and federal approval.
[48] The Department is currently working on developing an implementation project plan that will be shared with stakeholders at a future time; this will be a long-term, multi-step project and may require additional resources, such as future budget requests, in addition to CMS approval and an update to the MMIS.
[49] This includes investigating the impact of overnight respite, how to increase providers, and the impact of not having in-home respite available under the CMHS waiver. The Department is currently hiring for this project and plans to have more information on the scope and desired outcomes of this research by Fall 2022.
[50] This recommendation will be implemented upon state and federal approval, with a projected implementation date of January 1, 2023. These recommended rate changes are based on the current significant budget neutrality percent of the following services: ACF - 25.4%; Individual Residential Support Services - 58.26% to 24.48%, Group Residential Support Services (GRSS) - 40.11% to 10.81%; personal care (EBD, CMHS, BI, SCI) - 24.62%; personal care (SLS) - 17.66%; homemaker (EBD,CMHS, SCI and basic homemaker for SLS) - 4.91%; enhanced homemaker (SLS) - -2.78%. This recommendation may require additional resources, such as future budget requests. Any further rate changes will be implemented upon state and federal approval.

- personal care;
- homemaker (basic and enhanced);
- Day Habilitation;
- Adult Day;
- In-Home Support Services (IHSS) Health Maintenance Activities (HMA), IHSS personal care, and IHSS homemaker
- Consumer-Directed Attendant Support Services (CDASS) HMA, CDASS personal care, and CDASS homemaker; and
- ACF per diem rate.

TARGETED CASE MANAGEMENT (TCM)

ANALYSIS RESULTS

- Analyses suggest TCM payments at 87.84% of the benchmark were sufficient to allow for member access and provider retention.
- TCM individual rate ratios ranged from 66.52%-102.95% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Benefits of conflict-free case management.

DEPARTMENT FEEDBACK

- The Department is dedicated to complying by federal and state regulations regarding conflict-free case management; more information is located on the Conflict Free Case Management web page.[51]

WORKING RECOMMENDATIONS

- The Department recommends continuing support to the Case Management Redesign project to ensure evidence-based data and stakeholder perspectives inform project initiatives.[52]

[51] This project is projected to be completed by 2024.
[52] For more information, see the Case Management Redesign web page.