2023 Medicaid Provider Rate Review Analysis and Recommendation Report

November 1, 2023

Submitted to: The Joint Budget Committee and the Medicaid Provider Rate Review Advisory Committee

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Executive Summary

This report contains the Colorado Department of Health Care Policy & Financing's (HCPF) review of rates paid to providers under the Colorado Medical Assistance Act. This report is intended to be used by HCPF, in collaboration with the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and stakeholders, to evaluate findings and generate recommendations. Senate Bill 23-223 Medicaid Provider Rate Review Process reduced the rate review cycle so that each provider type is reviewed every three years instead of every five years. Services under review this year, Year One of the first three-year review cycle, are listed in the table below. The Rate Review Process, enacted in June 2015 by Senate Bill 15-228 and amended in June 2022 by Senate Bill 22-236 and June 2023 by Senate Bill 23-223, operates in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes).

This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder feedback, additional research, and recommendations for each service under review this year. The services are a subset of services reviewed throughout the entire three-year cycle. For each service grouping, rate benchmark comparisons describe (as a percentage) how Colorado Medicaid payments compare to other payers and are listed below.

Services Rate Benchmark Comparison Results	
Service	**CO as a Percent of Benchmark**
Anesthesia	137.5%
Ambulatory Surgical Centers	53.5%
Fee-for-Service Behavioral Health Services	97.0%
Pediatric Behavioral Therapy	78.7% for Method 1 - Including Nebraska; 90.7% for Method 2 - Excluding Nebraska
Maternity Services	76.1%
Abortion Services	N/A
Dental Services	49.8%

Table 1. Rate Benchmark Comparison Results

Surgeries Rate Benchmark Comparison Results	
Service	**CO as a Percent of Benchmark**
Digestive System	96.4%
Musculoskeletal System	66.4%
Cardiovascular System[1]	162.4%
Respiratory System	82.5%
Integumentary System	63.5%

[1] Here the benchmark ratio for cardiovascular surgery service is based on the repricing methodology which is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. In addition, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service."

Eye and Auditory System	95.0%
Other Surgeries	78.2%

Table 2. Surgeries Rate Benchmark Comparison Results

Using the recommendations from the MPRRAC process, HCPF staff prepare recommendations in accordance with anticipated budget restrictions for the coming fiscal year such as budget projections, HCPF's overall budget, and HCPF's budget relative to other state budget priorities. HCPF considers the MPRRAC's recommendations seriously when prioritizing HCPF recommendations; however, the budget allowance may not allow HCPF and MPRRAC recommendations to align.

The total anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$144,027,428 total funds, and $39,718,024** General Fund.

The total anticipated fiscal impact of HCPF's recommendations is predicted to be **$112,395,679 total funds, and $28,271,871 General Fund**.

Members of the public are invited to engage in the Rate Review Process; provide input on access, quality, and provider rates; and attend MPRRAC meetings. The three-year rate review schedule, the MPRRAC meeting schedule, past MPRRAC meeting materials, and more can be found on HCPF website.

Anesthesia

MPRRAC Recommendations:

- The MPRRAC suggests consideration of the difference between moderate and general sedation when it comes to reimbursement rates.
- Introduce a travel rate for anesthesia providers due to additional travel costs and an expected improvement of access to care.
- The MPRRAC members support reducing the rate to 100% of the benchmark, but voiced two main concerns:
    - Increased cost to supplies (example: COVID-19 protocols, supply chain issues, inflation).
    - Decreases may impact certain codes more than others.
- The anticipated fiscal impact of MPRRAC's recommendations is predicted to be **($9,897,967) total funds, ($2,896,344) General Fund.**

HCPF Recommendations:

- HCPF recommends a reduction in anesthesia service rates to 100% of the benchmark, which would be more in line with target and other providers, while allowing for funding to be more equitably distributed to other provider types.

- The anticipated fiscal impact of HCPF's recommendations is predicted to be **($9,897,967) total funds, and ($2,896,344) General Fund.**

Ambulatory Surgical Centers (ASCs)

MPRRAC Recommendations:

- The MPRRAC recommends an increase of ASC rates to at least 80% of the benchmark.
    - This is equivalent to increasing the current rates by 54%.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$5,379,889 total funds, $1,574,264 General Fund.**

HCPF Recommendations:

- HCPF recommends increasing ASC rates to 75% of the benchmark to encourage utilization of the ASC setting.
    - This is equivalent to increasing the current rates by 21.5%.
    - ASCs are an alternative care site to the outpatient hospital care site; adequate ASC access creates a cost efficient care alternative
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$4,366,634 total funds, $1,277,764 General Fund.**

Fee-for Service (FFS) Behavioral Health Services

MPRRAC Recommendations:

- The MPRRAC recommends a language translation modifier for native language speakers for testing codes.
- The MPRRAC recommends reviewing four psychological testing codes (96132, 96133, 96136, 96137) under fee-for-service behavioral health services, as opposed to reviewing under Physician Services category as done previously in the 2022 Medicaid Provider Rate Review Analysis Report.
    - Some members support a higher increase above 100%, while others recommend looking at specific codes (96132, 96133, 96136, 96137) to be above 100% in order to alleviate the bottleneck in accessing psychological assessments.
- The anticipated fiscal impact of the MPRRAC's recommendation is predicted to be **$319,452 total funds, $159,726 General Fund.**

HCPF Recommendations:

- HCPF recommends reverting the rates for 2 ASD/Development screening assessment codes (96110 and 96127) to $18.39 to reflect the rates before the

2019/2022 MPRRAC review plus the 3% across-the-board rate increase applied for FY 2023-24.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$1,664,157 total funds, $822,078 General Fund**.

Pediatric Behavioral Therapy (PBT)

MPRRAC Recommendations:

- The MPRRAC recommends increasing PBT rates to 100% of the benchmark that includes Nebraska (78.7%) and open up a list of codes that are not currently covered by Colorado Medicaid.
    - Codes include: 97152, 97156, 97157, 0362T, 0373T
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$34,281,532 total funds, $17,140,766 General Fund.**

HCPF Recommendations:

- HCPF recommends raising all rates to 100% of the benchmark, excluding Nebraska (90.7%).
    - Nebraska is an extreme outlier with rates that are between 41% - 508% above other states in the benchmark cohort. For example, the Nebraska rate for 97155 per unit is $36.11 in 2023, which is 41% higher than the average rate of other nine states. Its rate for 97158 per unit is $54.17, which is 508% higher than the average rate of other nine states.
    - Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year's rate increases.
- HCPF recommends leaving one procedure code (97158) at its current rate because its benchmark ratio is already at 128.5%, which is above the recommended 100% benchmark ratio of other four procedure codes.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$13,019,386 total funds, $6,509,693 General Fund**.

Maternity Services

MPRRAC Recommendations:

- The MPRRAC recommends an increase of maternity rates to 100% of the benchmark.

- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$8,942,246 total funds, $4,471,123 General Fund.**

HCPF Recommendations:

- HCPF recommends 13 out of 18 general maternity service and care codes increase to 100% of the benchmark (59160, 59300, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59614, 59618, 59622, 59830).
  - HCPF recommends that the 5 out of 18 general maternity service and care codes that are already above 90% remain at their current rate (59350, 59409, 59525, 59612, 59614).
- HCPF recommends 12 out of 14 non-viable pregnancy codes increase to 80% of the benchmark (59070, 59120,59121,59130,59150, 59001, 59015, 59200, 59812, 59820, 59821, 59870).
  - HCPF recommends that the 2 out of 14 non-viable pregnancy codes that are above 80% remain at their current rate (59025, 59151).
- HCPF recommends the 10 OB Global Bundled codes remain at their current rate (59000, 59012, 59051, 59140, 59320, 59412, 59414, 59514, 59620, 59871).
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$8,494,404 total funds, $4,247,202 General Fund.**

Abortion Services

MPRRAC Recommendations:

- The MPRRAC recommends increasing rates closer to other states' Medicaid programs because the rates are only reviewed every three years.
- One suggestion is a targeted rate increase because there is insufficient information due to HIPAA prohibiting the disclosure of codes with less than 30 claims; the MPRRAC raised concerns about how a rate increase may impact other services' rate increases:
  - Concerns about using different states as a benchmark because other factors may not be comparable to Colorado.
  - Concerns that Medicare is not used as the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is $0.

HCPF Recommendations:

- HCPF recommends raising the reimbursement rate for code 59840 (Dilation and Curettage) to $354.54
- HCPF recommends raising the reimbursement rate for code 59841 (Dilation and Evacuation) to $1,150.00.

- The anticipated fiscal impact of HCPF's recommendations is predicted to be **$325 total funds, $162 General Fund.**

Dental Services

MPRRAC Recommendations:

- The MPRRAC recommends that the 24 preventative, endodontic, periodontic and diagnostic dental codes submitted by the Colorado Dental Association be increased to 100% of the commercial benchmark to have the most immediate impact on the dental community. These 24 dental codes are high value codes with the most immediate impact on the Colorado dental community.
- The 24 identified codes are: D0120, D0140, D0150, D1110, D1120, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930, D3310, D3320, D3330, D3346, D3347, D3348, D4341, D4342, and D4910.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$104,138,137 total funds, $19,015,624 General Fund.**

HCPF Recommendations:

- HCPF recommends increasing preventative dental codes (D1110, D1120), endodontic codes (D3310, D3320, D3330, D3346, D3347, D3348) and periodontic codes (D4341, D4342 and D4910) to 100% of the benchmark. This aligns with incentivizing dental prevention and efforts to improve member access and equity in oral health care.
- HCPF recommends the remaining 13 codes for diagnostic services (D0120, D0140, D0150,D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930) increase to 70% of the benchmark.
- HCPF recommends raising 4 additional preventative procedure codes: D1206, D1351, D1352, D1354 (3 codes are for sealants and 1 is for silver diamine fluoride to arrest decay) to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$85,620,023 total funds, $15,634,217 General Fund**.

Digestive System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends keeping preventative surgery codes at 100% of the benchmark.
  - Preventative surgery codes include:
    - 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.

- For all other codes, rebalance to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **($1,447,136) total funds, ($423,461) General Fund.**

HCPF Recommendations:

- HCPF recommends raising preventative surgery codes to 100% of the benchmark and keeping any preventative codes over 100% at their current rate.
    - Preventative surgery codes include: 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.
- HCPF recommends a rebalance of all other codes, meaning codes below 70% of the benchmark be increased to 70%, and codes above 100% of the benchmark be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **($1,165,252) total funds, ($340,976) General Fund.**

Musculoskeletal System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$5,003,658 total funds, $1,464,171 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes, with codes below the 70% benchmark increased to 70% and codes above 100% of the benchmark reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$3,732,671 total funds, $1,092,254 General Fund.**

Cardiovascular System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **($7,723,131) total funds, ($2,259,943) General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 125% of the benchmark to be reduced to 125% using only non-facility Medicare rates as the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$2,842,496 total funds, $831,772 General Fund.**

Respiratory System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$180,879 total funds, $52,929 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **($223,909) total funds, ($65,520) General Fund.**

Integumentary System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$3,216,801 total funds, $941,300 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
  - HCPF recommends 1 preventative code (17380) to increase to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$2,081,628 total funds, $609,126 General Fund.**

Eye and Auditory Systems Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.

- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **($176,581) total funds, ($51,671) General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **($383,945) total funds, ($112,350) General Fund.**

Other Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **$1,809,649 total funds, $529,540 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **$505,358 total funds, $147,878 General Fund.**

Co-Surgery

MPRRAC Recommendations:

- The MPRRAC did not receive data on Co-Surgery, and therefore did not make a recommendation.

HCPF Recommendations:

- HCPF recommends to expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes 2,469 codes.
- The anticipated fiscal impact of the co-surgery recommendation is about **$1,759,670 total funds, $514,915 General Fund.**

Introduction

The Colorado Department of Health Care Policy & Financing (HCPF) administers the State's public health insurance programs, including Colorado's Medicaid, Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. HCPF's mission is to improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

In 2015, the Colorado General Assembly adopted Senate Bill 15-228, "Medicaid Provider Rate Review," amended by Senate Bill 22-236 in 2022, an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with the Colorado Medical Assistance ACT, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes), HCPF established a rate review process that involves three components:

- assess and, if needed, review a three-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review;
- provide recommendations on all rates reviewed and present them in a report published the first of every November.

The Rate Review Process is advised by the MPRRAC, whose members recommend changes to the three-year schedule, provide input on reports published by HCPF, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year One of the first three-year rate review cycle, began in March 2023 and included a general discussion of services under review and stakeholder feedback. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are found on HCPF website.

This report contains:

- comparisons of Colorado Medicaid provider rates to those of other payers;
- access to care analyses; and
- assessments of whether payments were sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services, including where additional research is necessary to identify potential access issues.

Payment Philosophy

The Rate Review Process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process, which includes

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feedback from the MPRRAC, has helped inform HCPF's payment philosophy for fee-for-service (FFS) rates.

Where Medicare is an appropriate comparator, HCPF believes that, in many circumstances, a reasonable threshold for payments is 80% - 100% of Medicare; however, there are four primary situations where Medicare may not be an appropriate model when comparing a rate, including, but not limited to:

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., dental & maternity services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid.
3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar (e.g., some health education services).
4. There is a known issue with Medicare's rates (e.g., home health services).

When Medicare is not an appropriate comparator, HCPF may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While HCPF has historically viewed payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below, must be considered when setting or changing a rate. These include:

- budget constraints that may prevent payment at a certain amount;
- investigating whether a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies;
- identifying certain services where HCPF may want to adjust rates to incentivize utilization of high value services;
- complaints received from primary care physicians (PCP) and members indicating that specialists, while enrolled in the Medicaid network, are not accepting Medicaid patients for care, thus impeding member access; the access appears to exist measured by specialty provider enrollment but is not equally presenting via the patient or PCP experience; and
- developing systems to ensure that payments are associated with high-quality provision of services.

When the Rate Review Process indicates a current rate does not align with HCPF's payment philosophy, HCPF may recommend or implement a rate change. It is also important to note that HCPF may or may not recommend a change, due to the considerations listed above.

Format of Report

Information below explains the sections within each service grouping of the report, including each section's basic structure and content.

Service Description

Service definitions, procedure or revenue codes, and member and provider data are outlined in this section. This section is designed to provide the reader with an understanding of the service grouping under review, as well as the scale of members utilizing and providers delivering this service grouping. Summary statistics are provided for each service grouping. Those statistics and time period they represent are:

- Total Adjusted Expenditures – FY 2021-22.
- Total Members Utilizing Services – FY 2021-22.
- Year-over-year Change in Members Utilizing Services – FY 2020-21 – FY 2021-22
- Total Active Providers – FY 2021-22.
- Year-over-year Change in Active Providers – FY 2020-21 – FY 2021-22

Rate Comparison Analysis

HCPF contracted with the actuarial firm, Optumas, to assist in the comparison of Colorado Medicaid provider rates to those of other payers. The resulting rate comparison analysis outlined in this section provides a reference point for how Colorado Medicaid reimbursement rates compare to other payers.

Analysis in this section is based on FY 2021-22 administrative claims data and contains a rate benchmark comparison, which describes (as a percentage) how Colorado Medicaid payments compare to other payers. This section also lists the number of procedure codes compared to either Medicare or an average of other states' Medicaid rates, and the range of individual rate ratios.

HCPF first examined whether a service had a corresponding Medicare rate to identify comparator rates for analysis. Medicare rates were primarily relied upon for this analysis when available and appropriate. When Medicare rates were unavailable, HCPF relied upon other state Medicaid agency rates when the benchmark states have applicable fee-for-service rates for the service category. HCPF utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates;
- Medicare's rates, methodologies, and service definitions are generally available to the public;
- Medicare's rates are typically updated on a periodic basis; and
- Most services covered by Colorado Medicaid are also covered by the Medicare program.

Access to Care Analysis

HCPF contracted with the Center for Improving Value in Health Care (CIVHC) to assist in evaluating access. The access to care analysis shows provider participation within each service under review. It should be noted that this metric does not measure actual utilization compared to network enrollment, creating an opportunity going forward. Again, a provider may be enrolled in Medicaid but is not accepting patient referrals, due to Medicaid reimbursement rates or other factors. HCPF is now reviewing all enrolled specialists to identify providers not seeing enough Medicaid members. For the purposes of this current report the current access to care metrics do not indicate how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurance, or to the uninsured population. HCPF and MPRRAC will explore ways to expand the access to care analysis in future review cycles.

Stakeholder Feedback

This section contains summaries of stakeholder comments received during the Rate Review Process.

Additional Research

For certain service groupings and regions, particularly when HCPF's analysis indicated a potential access issue, HCPF will work to identify other data sources that may be used to conduct additional research during the MPRRAC process. These data sources may be created and maintained as part of HCPF's ongoing benefit management and programmatic operations, while others may be created by other organizations or State agencies. HCPF plans to use these data sources to conduct further research as HCPF's 2023 Medicaid Provider Rate Review Analysis Report is developed. Options for additional research include:

- Examining claims and enrollment data to understand if members are accessing services in settings, or via delivery systems, that are excluded from the rate review analysis.

- Reviewing relevant, regional results on Key Performance Indicators (KPIs), which are tracked as a part of Colorado Medicaid's delivery system, the Accountable Care Collaborative.

- Reviewing relevant, practice-level results on quality metrics, including Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures.

- Working with HCPF's provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.

- Seeking information from the State Health Care Workforce Work team to determine the general impact of health care workforce burnout, inflation, and health care workforce shortages to understand how Medicaid reimbursement rates might have to be adjusted due to these COVID19 induced factors.

- Examining regional and statewide reports and studies published by other agencies, such as the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Recommendations

This section lists MPRRAC's and HCPF's recommendations for Year One (Cycle One) services as a result of the Rate Review Process. Additionally, stakeholder feedback during MPRRAC meetings is helpful for identifying additional areas for evaluation. For these reasons, some recommendations focus on further research rather than direct action on rates or policy.

Limitations

Results from this report, emerging macro and micro environmental factors (i.e.: inflation, health care workforce burnout, health care workforce shortages, etc.) and additional research will inform the development of HCPF Recommendations. Still, it is important to note limitations inherent to analyses in this report and limitations that exist generally when evaluating payment sufficiency and access to care.

The access to care analyses and resulting conclusions are based on administrative claims data. Claims-based analyses do not provide information regarding appointment wait times, quality of care, or differences in provider availability and service utilization based on insurance type; nor do claims-based analyses allow for HCPF to quantify care that an individual may have needed but did not receive nor the provider enrollment versus providers seeing Medicaid patients. In addition, data analyses use active providers, which includes any rendering provider with at least one Colorado Medicaid paid claim in a given month between July 2021 - June 2022. HCPF plans to create additional internal insight reports and to evaluate other data sources to address this. When HCPF evaluates other data sources, there may be assumptions and extrapolations made due to differences in geographic area designations, differences in population definitions, and differences in service definitions. Additionally, many of the access to care indicators are relative, and without defined standards, cannot indicate if all regions are performing well or if all regions are performing poorly.

However, these indicators, when analyzed all together, can help identify regions for focus.

There are complicating factors regarding determining rate sufficiency. Member access and provider retention are influenced by factors beyond rates, such as: provider outreach and recruitment strategies; the administrative burden of program participation; health literacy and healthcare system navigation ability; provider scheduling and operational practices; and member characteristics and behaviors. Additionally, rates may not be at their optimal level, even when there is no indication of member access or provider retention issues. For example, rates that are above optimal may lead to decreases in the provision of high-quality care or increases in the provision of services in a less cost-effective setting.

Anesthesia

Service Description

The anesthesia service grouping consists of 291 procedure codes (including reviewed and excluded procedure codes). Anesthesia includes general, local, and conscious sedation done to permit the performance of medical, surgical, and radiological procedures. Anesthesia services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Anesthesia Statistics	
Total Adjusted Expenditures FY 2021-22	$34,584,601
Total Members Utilizing Services in FY 2021-22	90,868
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	3.9%
Total Active Providers FY 2021-22	1,764
FY 2021-22 Over FY 2020-21 Change in Active Providers	2.3%

Table 3. Anesthesia expenditure and utilization data (FY 2021-22).

Rate Comparison Analysis

On average, Colorado Medicaid payments for anesthesia services are estimated at 137.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Anesthesia Rate Benchmark Comparison		
Colorado Repriced	**Medicare Repriced**	**Rate Benchmark Comparison**
$36,268,689	$26,370,722	137.5%

Table 4. Comparison of Colorado Medicaid anesthesia service payments to those of other payers expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be ($9,897,967) total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 291 procedure codes analyzed in this service grouping, 246 were compared to Medicare (84.5%), 39 did not have applicable repricing rates, and 6 did not have valid utilization in FY 2021-22. Individual rate ratios for anesthesia services were 129% - 271.7%.

Access to Care Analysis

The provider participation rate for anesthesia services is 53%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

In 2020, HCPF lowered anesthesia rates to match Medicare rates, however; in 2021 Medicare lowered their rates once again which left the state of Colorado's rates higher than Medicare. HCPF was unaware of the difference in rates until research and data were pulled for this report.

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	00840	ANESTH SURG LOWER ABDOMEN	$ 2,395,330	$ 2,520,471	$ 1,855,995	135.8%
2	00731	ANES UPR GI NDSC PX NOS	$ 2,227,284	$ 2,340,760	$ 1,723,416	135.8%
3	01967	ANESTH/ANALG VAG DELIVERY	$ 2,212,667	$ 2,330,266	$ 1,701,946	136.9%
4	00790	ANESTH SURG UPPER ABDOMEN	$ 2,011,803	$ 2,114,520	$ 1,558,012	135.7%
5	00170	ANESTH PROCEDURE ON MOUTH	$ 1,773,391	$ 1,863,439	$ 1,372,739	135.7%
6	01961	ANESTH CS DELIVERY	$ 1,156,876	$ 1,215,022	$ 829,556	146.5%
7	00670	ANESTH SPINE CORD SURGERY	$ 1,076,582	$ 1,131,195	$ 833,570	135.7%
8	01480	ANESTH LOWER LEG BONE SURG	$ 983,851	$ 1,033,660	$ 761,279	135.8%
9	01922	ANESTH CAT OR MRI SCAN	$ 967,917	$ 1,017,433	$ 748,485	135.9%
10	00811	ANES LWR INTST NDSC NOS	$ 938,046	$ 985,800	$ 726,182	135.8%

Table 5. Top 10 codes utilized for anesthesia services (FY 2021-22).

HCPF identified 25 outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
01968	ANES/ANALG CS DELIVER ADD-ON	$ 236,571	$ 180,950	$ 128,431	140.9%
00540	ANESTH CHEST SURGERY	$ 61,547	$ 64,664	$ 45,737	141.4%
00865	ANESTH REMOVAL OF PROSTATE	$ 35,730	$ 37,555	$ 26,446	142.0%
01925	ANES THER INTERVEN RAD CARD	$ 18,478	$ 19,413	$ 13,554	143.2%
01924	ANES THER INTERVEN RAD ARTRL	$ 96,544	$ 101,430	$ 70,313	144.3%
01931	ANES THER INTERVEN RAD TIPS	$ 40,369	$ 42,413	$ 29,215	145.2%
01960	ANESTH VAGINAL DELIVERY	$ 1,958	$ 2,077	$ 1,427	145.6%
00567	ANESTH CABG W/PUMP	$ 109,087	$ 114,656	$ 78,412	146.2%
01961	ANESTH CS DELIVERY	$ 1,156,876	$ 1,215,022	$ 829,556	146.5%
01933	ANES TX INTERV RAD CRAN VEIN	$ 2,729	$ 2,868	$ 1,956	146.6%
00834	ANESTH HERNIA REPAIR < 1 YR	$ 12,541	$ 13,176	$ 8,934	147.5%
01770	ANESTH UPPR ARM ARTERY SURG	$ 13,703	$ 14,397	$ 9,729	148.0%
00851	ANESTH TUBAL LIGATION	$ 135,080	$ 141,329	$ 94,914	148.9%
01963	ANESTH CS HYSTERECTOMY	$ 1,161	$ 1,220	$ 815	149.7%
01926	ANES TX INTERV RAD HRT/CRAN	$ 203,665	$ 214,017	$ 142,131	150.6%
01214	ANESTH HIP ARTHROPLASTY	$ 340,959	$ 358,281	$ 236,454	151.5%
00147	ANESTH IRIDECTOMY	$ 877	$ 922	$ 595	154.9%
01930	ANES THER INTERVEN RAD VEIN	$ 84,478	$ 88,788	$ 57,319	154.9%
01932	ANES TX INTERV RAD TH VEIN	$ 6,743	$ 7,084	$ 4,537	156.1%
01952	ANESTH BURN 4-9 PERCENT	$ 83,657	$ 87,892	$ 52,731	166.7%
00326	ANESTH LARYNX/TRACH < 1 YR	$ 64,750	$ 68,037	$ 40,499	168.0%
00142	ANESTH LENS SURGERY	$ 491,864	$ 516,932	$ 283,291	182.5%
01951	ANESTH BURN LESS 4 PERCENT	$ 30,874	$ 32,457	$ 15,469	209.8%
01953	ANESTH BURN EACH 9 PERCENT	$ 14,632	$ 496	$ 197	251.9%
00635	ANESTH LUMBAR PUNCTURE	$ 208,074	$ 218,718	$ 80,493	271.7%

Table 6. Outliers for anesthesia services (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

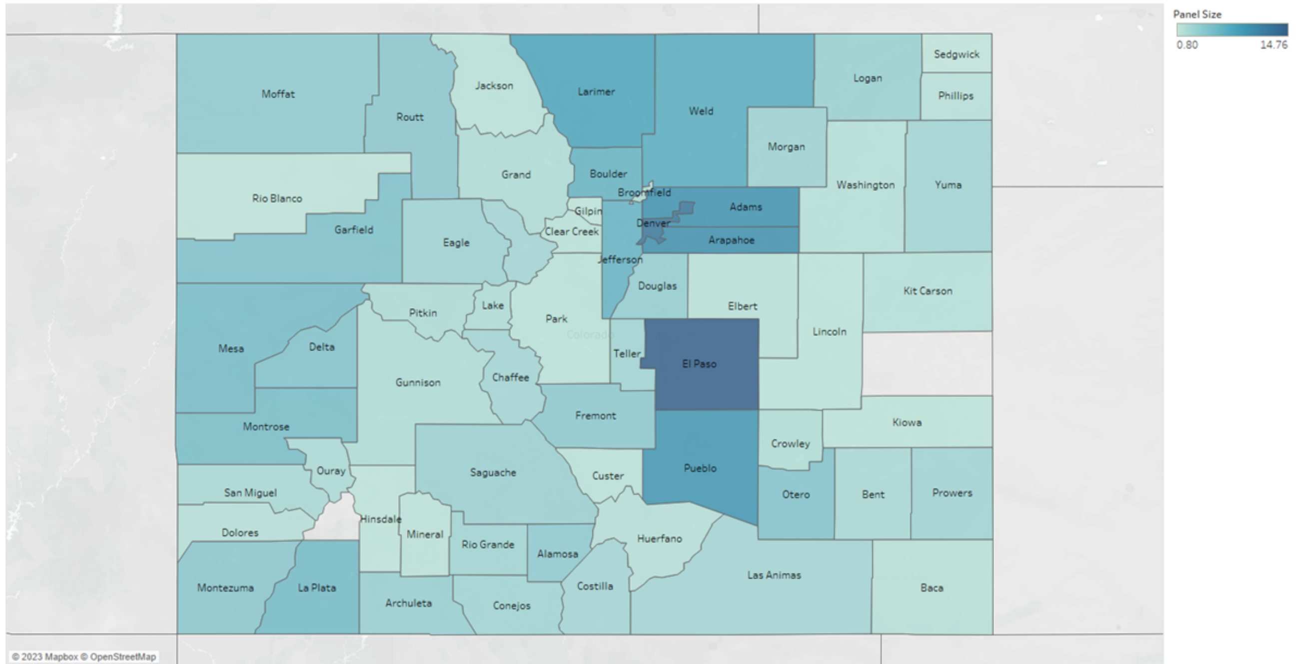

Figure 1. Anesthesia utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC suggests consideration of the difference between moderate and general sedation when it comes to reimbursement rates.
- The MPRRAC recommends introducing a travel rate for anesthesia providers due to additional travel costs and an expected improvement of access to care.
- The MPRRAC members support bringing down the rate to 100% of the benchmark, however voiced two main concerns:
    - Increase of cost to supplies (example: COVID-19 protocols, supply chain issues, inflation).
    - Decreases may impact certain codes more than others.
- The anticipated fiscal impact of MPRRAC's recommendations is predicted to be ($9,897,967) total funds, ($2,896,344) General Fund.

HCPF Recommendations

- HCPF recommends a reduction in anesthesia service rates to 100% of the benchmark.
- The anticipated fiscal impact of HCPF's recommendations is predicted to be ($9,897,967) total funds, and ($2,896,344) General Fund.

HCPF COLORADO Department of Health Care Policy & Financing

Policy Justification

HCPF agrees with MPRRAC's recommendation to bring rates down to 100% of the benchmark. However, HCPF disagrees with introducing a travel rate for traveling anesthesia providers because HCPF does not have a clear idea of what travel rates for anesthesia providers would look like or how it would function in practice. HCPF does not currently have any way to differentiate services by traveling anesthesiologists from other anesthesia services so it's difficult to estimate what kind of expenditure this would be. If HCPF were to identify a modifier, providers could use this to indicate travel that would correspond to a higher rate. HCPF would also need to implement some kind of oversight that currently does not exist to ensure appropriate utilization.

Ambulatory Surgical Centers

Service Description

The ambulatory surgical centers (ASCs) service grouping comprises 11 groupers. ASCs are distinct entities that provide a surgical setting for members who do not require hospitalization. ASC services were previously reviewed in the 2019 Medicaid Provider Rate Review Analysis Report.

Ambulatory Surgical Centers Statistics	
Total Adjusted Expenditures FY 2021-22	$13,381,112
Total Members Utilizing Services in FY 2021-22	21,795
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	9.6%
Total Active Providers FY 2021-22	305
FY 2021-22 Over FY 2020-21 Change in Active Providers	12.1%

Table 7. Ambulatory Surgical Centers expenditure and utilization data (FY 2021-22).

Rate Comparison Analysis

On average, Colorado Medicaid payments for ASC services are estimated at 53.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Ambulatory Surgical Centers Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$10,832,192	$20,265,101	53.5%

Table 8. Comparison of Colorado Medicaid Ambulatory Surgical Centers service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $9,432,909 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 11 groupers analyzed in this service grouping, 10 were compared to Medicare (90.9%), and 1 did not have valid utilization during FY 2021-22. Grouper rate ratios for ASCs services were 26.2% - 79.5%.

Access to Care Analysis

The provider participation rate for ASC services is 43%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. However, comparison by procedure code was not an accurate representation for the ASC service category due to differences in payment methodologies between Medicare and Colorado Medicaid. Instead, HCPF compared payments in aggregate by ASC grouper. Payments were combined for each procedure code in each grouper for Medicaid and Medicare, then aggregate Medicaid payments were divided by aggregate Medicare payments. The table on the right depicts the benchmark percentages using the discounts under Medicare for multiple procedures done at the same time.

Repriced Medicare - Primary Line Only			
Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A01	$ 2,063,865	$ 3,627,303	56.9%
A02	$ 3,792,552	$ 5,700,607	66.5%
A03	$ 834,843	$ 3,187,907	26.2%
A04	$ 603,662	$ 1,702,973	35.4%
A05	$ 595,826	$ 1,605,658	37.1%
A06	$ 250,098	$ 738,342	33.9%
A07	$ 253,733	$ 611,368	41.5%
A08	$ 1,629,422	$ 2,050,309	79.5%
A09	$ 383,337	$ 505,154	75.9%
A10	$ 424,854	$ 535,480	79.3%
A11	$ -	$ -	0.0%
Total	**$ 10,832,192**	**$ 20,265,101**	**53.5%**

Repriced Medicare - Multiple Procedure Discount			
Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A01	$ 2,063,865	$ 4,306,859	47.9%
A02	$ 3,792,552	$ 7,054,236	53.8%
A03	$ 834,843	$ 3,941,267	21.2%
A04	$ 603,662	$ 1,961,016	30.8%
A05	$ 595,826	$ 1,707,423	34.9%
A06	$ 250,098	$ 781,022	32.0%
A07	$ 253,733	$ 628,474	40.4%
A08	$ 1,629,422	$ 2,068,211	78.8%
A09	$ 383,337	$ 524,014	73.2%
A10	$ 424,854	$ 565,387	75.1%
A11	$ -	$ -	0.0%
Total	**$ 10,832,192**	**$ 23,537,908**	**46.0%**

Table 9. The table on the left shows Medicaid payments compared to Medicare if Medicare used the same payment methodology as the State of Colorado while the table on the right shows the rate comparison with Medicare's multiple procedure discounting methodology included in the Medicare repricing. (FY 2021-22).

HCPF identified 6 ASC grouper outliers:

Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A03	$ 834,843	$ 3,187,907	26.2%
A06	$ 250,098	$ 738,342	33.9%
A04	$ 603,662	$ 1,702,973	35.4%
A05	$ 595,826	$ 1,605,658	37.1%
A07	$ 253,733	$ 611,368	41.5%
A01	$ 2,063,865	$ 3,627,303	56.9%

Table 10. Outlier for ASC services (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

ASC Panel Size

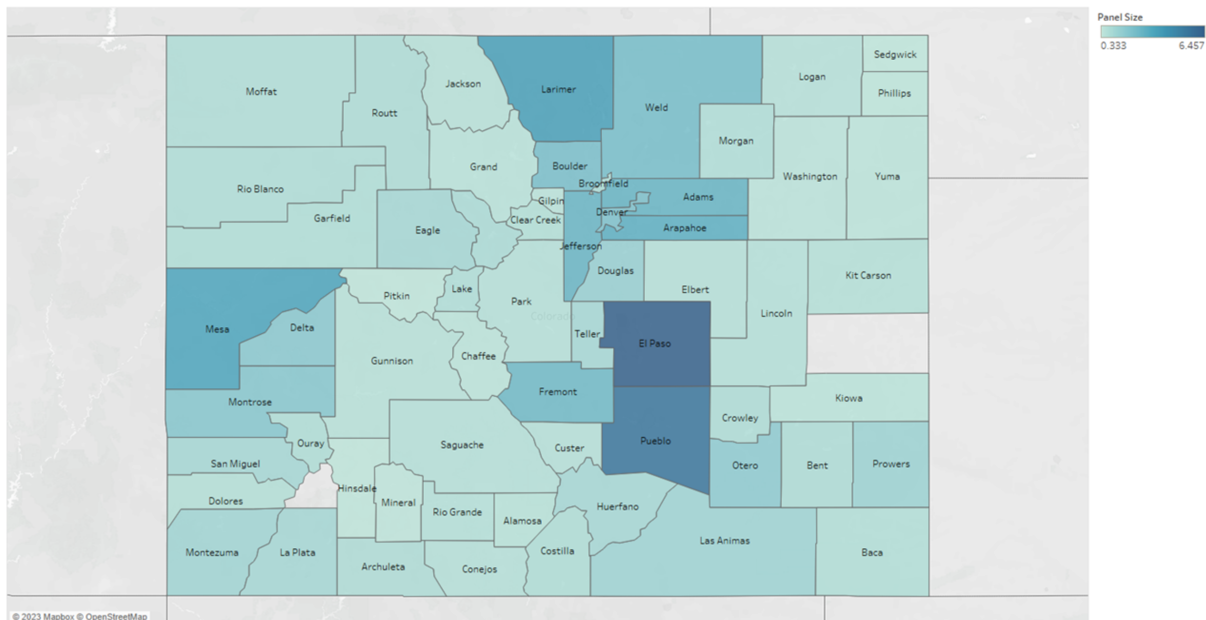

Figure 2. ASC utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends an increase of ASC rates to at least 80% of the benchmark.
  - This is equivalent to increasing the current rates by 54%
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $5,379,889 total funds, $1,574,264 General Fund.

HCPF Recommendations

- HCPF recommends a reform in payment methodology for ASC providers to the existing Enhanced Ambulatory Patient Grouper methodology utilized for Outpatient Hospital claims.
- HCPF recommends increasing ASC rates to 75% of the benchmark.
  - This is equivalent to increasing the current rates by 21.5%
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $4,366,634 total funds, $1,277,764 General Fund.

Policy Justification

HCPF recommends an increase to 75% of the benchmark rather than MPRRAC's 80% in an effort to encourage greater utilization of lower-cost options for surgeries while working towards an updated payment methodology that will address the majority of

ASC rate concerns. Further, the benchmark is an inaccurate comparison because Medicare does not pay the same way that Medicaid pays.

Fee-for-Service Behavioral Health Services

Service Description

The fee-for-service (FFS) behavioral health service grouping consists of 31 procedure codes. HCPF pays for a small number of behavioral health services directly (FFS), outside of the Capitated Behavioral Health Benefit. A behavioral health code is paid FFS when the service is provided for a diagnosis not covered in the managed care benefit, such as when a psychological assessment is required for a surgical procedure; if it is not a procedure covered by managed care benefit, such as developmental testing even if completed by a psychologist; or if it is billed for a member who is not assigned to a regional accountable entity, usually due to retroactive billing for newly enrolled members. This set of codes reviewed was specific to mental health and neuropsychological codes, and does not include substance use codes. Additionally, the Short Term Behavioral Health Visit benefit is reimbursed by FFS. It is limited to six visits per member per year. Only FFS behavioral health rates are included in the analysis. Most codes under FFS behavioral health services were previously reviewed in the 2019 Medicaid Provider Rate Review Analysis Report. However, some codes that are now under FFS behavioral health services were previously reviewed under Physician - Cognitive Capabilities in the 2022 Medicaid Provider Rate Review Analysis Report.

Fee-for-Service Behavioral Health Services Statistics	
Total Adjusted Expenditures FY 2021-22	$18,734,736
Total Members Utilizing Services in FY 2021-22	112,683
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	8.8%
Total Active Providers Billing FFS BH in FY 2021-22	3,699
FY 2021-22 Over FY 2020-21 Change in Active Providers	12.5%

Table 11. Fee-for-Service Behavioral Health Services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS Behavioral Health Services are estimated at 97.0% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

COLORADO
Department of Health Care Policy & Financing

Fee-for-Service Behavioral Health Services Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$18,175,906	$18,732,206	97.0%

Table 12. Comparison of Colorado Medicaid Fee-for-Service Behavioral Health Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $556,300 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 31 procedure codes analyzed in this service grouping, 30 were compared to Medicare (96.8%), and 1 (96110) was compared to other states. Individual rate ratios for FFS Behavioral Health Services were 51.1% - 401.3%.

Access to Care Analysis

The provider participation rate for FFS Behavioral Health Services is 49%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	Utilization (Units)	TPL & Copayments	CO Repriced	Medicare/Other States Repriced	Medicare/Other States Repriced - TPL	CO as a % of Benchmark
1	90833	PSYTX W PT W E/M 30 MIN	$ 2,991,449	48,271	$ 12,173	$ 2,966,166	$ 3,385,749	$ 3,373,576	87.9%
2	96133	NRPSYC TST EVAL PHYS/QHP EA	$ 2,550,220	26,338	$ 24,528	$ 2,624,244	$ 2,648,772	$ 2,624,244	100.0%
3	90837	PSYTX W PT 60 MINUTES	$ 2,023,517	16,608	$ 25,856	$ 2,164,301	$ 2,469,510	$ 2,443,655	88.6%
4	96137	PSYCL/NRPSYC TST PHY/QHP EA	$ 1,968,512	42,829	$ 20,761	$ 2,071,844	$ 1,734,130	$ 1,713,369	120.9%
5	96127	BRIEF EMOTIONAL/BEHAV ASSMT	$ 1,575,164	95,190	$ 12,738	$ 453,693	$ 466,431	$ 453,693	100.0%
6	90791	PSYCH DIAGNOSTIC EVALUATION	$ 1,273,263	8,583	$ 17,008	$ 1,326,590	$ 1,518,265	$ 1,501,256	88.4%
7	96132	NRPSYC TST EVAL PHYS/QHP 1ST	$ 1,155,444	9,394	$ 11,773	$ 1,227,014	$ 1,238,787	$ 1,227,014	100.0%
8	96110	DEVELOPMENTAL SCREEN W/SCORE	$ 641,978	50,782	$ 5,590	$ 568,247	$ 475,827	$ 470,238	120.8%
9	90836	PSYTX W PT W E/M 45 MIN	$ 607,372	8,111	$ 5,279	$ 627,947	$ 721,311	$ 716,032	87.7%
10	90792	PSYCH DIAG EVAL W/MED SRVCS	$ 597,085	3,679	$ 13,913	$ 629,544	$ 730,245	$ 716,331	87.9%

Table 13. Top 10 codes utilized for Fee-for-Service Behavioral Health services (FY 2021-22).

HCPF identified two outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
96139	PSYCL/NRPSYC TST TECH EA	$ 62,362	$ 65,581	$ 128,341	51.1%
96146	PSYCL/NRPSYC TST AUTO RESULT	$ 64.19	$ 67.41	$ 16.80	401%

Table 14. Outlier for Fee-for-Service Behavioral Health services codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

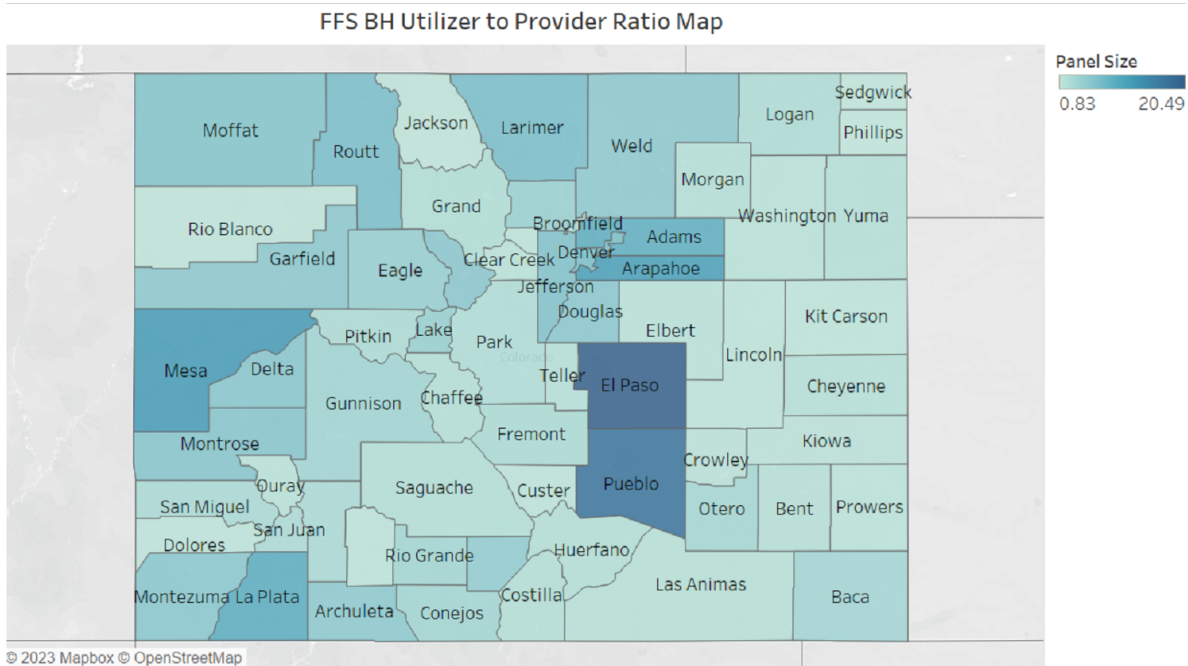

Figure 3. Fee-for-Service Behavioral Health services utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends a language translation modifier for native language speakers for testing codes.
- The MPRRAC recommends reviewing four psychological testing codes (96132, 96133, 96136, 96137) under fee-for-service behavioral health services, as opposed to reviewing under Physician Services category as done previously in the 2022 Medicaid Provider Rate Review Analysis Report.
    - Some members support a higher increase above 100%, while others recommend looking at specific codes (96132, 96133, 96136, 96137) to be above 100% in order to alleviate the bottleneck in accessing psychological assessments.
- The anticipated fiscal impact of the MPRRAC's recommendation is predicted to be $319,452 total funds, $159,726 General Fund.

COLORADO
Department of Health Care Policy & Financing
HCPF

HCPF Recommendations

- HCPF recommends reverting the rates for 2 ASD/Development screening assessment codes (96110 and 96127) to $18.39 to reflect the rates before the 2019/2022 MPRRAC review plus the 3% across-the-board rate increase applied for FY 2023-24.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $1,664,157 total funds, $822,078 General Fund.

Policy Justification

Two assessment codes, 96127 and 96110, are used in Colorado for Developmental screenings (96110) and screenings for Autism Spectrum Disorder (ASD) (96127) by primary care physicians. Unfortunately, there are no appropriate Medicare benchmarks for these codes.

HCPF removed these codes from the mental health subset of codes and reviewed them under the physician services codes in 2018. This HCPF specific use of code 96127 is due to the requirement from CMS in 2020 that states were to separate developmental and ASD screenings from each other for mandatory reporting. A 2020 physician and stakeholder workgroup made the recommendations to use these two codes for the required reporting. That change was noticed in the June 2020 HCPF provider bulletin. The use of the codes and the provider bulletin were not reviewed by the MPRRAC committee when reviewing these codes. It is important to note that the rates for these codes were significantly higher than Medicare due to their use in ASD screenings for children, which is not common in Medicare.

These codes provide the same services, just with a different screening tool. The price differential approved by the MPRRAC committee last year is not sustainable for providers. Doctors and therapists now recognize the importance of early intervention when it comes to ASD. Studies suggest early intervention may be even more beneficial. In fact, children who receive intensive therapy early in their life span move higher on the ASD scale and around 20% are able to move out of the spectrum. However, the screening needs to be accomplished to rule children into the appropriate services. If children are not screened for ASD in pediatric and other primary care offices at 9, 18 and 30 months, they will not be able to access early and timely services, leaving the state at risk of needing to provide more treatment to an older child with less benefit. Therefore the codes should be reverted to their prior rates and be priced the same.

Although MPRRAC recommends four codes to be raised to 100% of the benchmark, due to budget restraints HCPF will not be prioritizing funding for this code set due to already being at 97% average. HCPF has previously explored a billing code for translation services, which was ruled out due to cost and therefore not included in

HCPF's recommendation. There can be further research exploring this language translation modifier in the future.

Pediatric Behavioral Therapy

Service Description

The pediatric behavioral therapy (PBT) service grouping consists of 6 procedure codes/ modifier combinations. PBT services consist of adaptive behavior treatment services, as well as evaluation and assessment services, for children ages 0-20. PBT services are covered by Early Periodic Screening, Diagnostic, and Treatment (EPSDT). This benefit was created through EPSDT in January 2018, after being removed as a waiver service. These services are provided both in home and clinical settings. PBT services were previously reviewed in the 2020 Medicaid Provider Rate Review Analysis Report.

Pediatric Behavioral Therapy Statistics	
Total Adjusted Expenditures FY 2021-22	$124,914,666
Total Members Utilizing Services in FY 2021-22	5,371
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	18.1%
Total Active Providers FY 2021-22	820
FY 2021-22 Over FY 2020-21 Change in Active Providers	24.1%

Table 15. Pediatric Behavioral Therapy expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for PBT services are estimated at 78.7% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Pediatric Behavioral Therapy Rate Benchmark Comparison		
Colorado Repriced	**Other States Repriced**	**Rate Benchmark Comparison**
$126,433,251	$160,714,783	78.7%

Table 16. Comparison of Colorado Medicaid Pediatric Behavioral Therapy service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $34,281,532 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 6 procedure codes/ modifier combinations analyzed in this service grouping, 5 were compared to an average of ten other states' (Florida, Massachusetts, Maryland, North Carolina,

Nebraska, Nevada, Oregon, Texas, Utah, Washington) Medicaid rates with 1 having no comparable rate. Individual rate ratios for PBT services were 36.0% - 84.8%.

Access to Care Analysis

The provider participation rate for PBT services is 85%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. However, there are only six codes under review. During the rate research process, HCPF found that the 97151 + TJ (behavior identification re-assessment code) modifier is specific to Colorado and not used by other states. Therefore, the transformation for the procedure code 97151 without modifier in Colorado specifically was taking the flat rate of $330.94 (Colorado Medicaid assumes 8 hours total when billing 97151 versus other states' billing per 15-minutes), dividing by 15 minutes to come to the conclusion of the Colorado reimbursement rate of $10.34 per 15-minute unit, which further translates to $9.80 per 15-minute unit after living cost adjustment. With this translation established, HCPF removed 97151 + TJ out of the analysis.

Here, the cost of living adjustment index reflected the timeframe of 2023 Q1, which was downloaded from Missouri Economic Research and Information Center on July 18, 2023. The underlying data source is the C2ER (Council for Community & Economic Research) Cost of Living Index, which is ranked as one of the most reliable source of region-to-region quarterly comparisons of key consumer costs and is referenced by many academic articles posted on the Census Academy of United States Census Bureau.

HCPF conducted a rate comparison analysis with cost of living adjustment considered. There were 7 states selected for the first round PBT analysis: Florida, Louisiana, North Carolina, Nevada, Texas, Utah, and Washington. Six out of these seven states were selected for the second round of PBT analysis and Louisiana was removed as the PBT service is under a managed care model. Based on data from Colorado Association for Behavior Analysis (COABA), Nebraska was added to the analysis. In addition, Dr. Peter Walsh (Chief Medicaid Officer at HCPF) recommended Oregon and Gina Robinson (PBT Subject Matter Expert at HCPF) suggested Massachusetts and

Michigan. The PBT fee schedule data was not able to be retrieved from Michigan state Medicaid website due to a technical issue, so Michigan was replaced with Maryland. The final states used in the analysis are: Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington. HCPF acknowledges that four of the states used in this comparison have a higher cost of living than Colorado (Massachusetts, Maryland, Oregon, Washington), while six have a lower cost of living (North Carolina, Nebraska, Texas, Florida, Nevada, Utah). All of the comparison states have a similar fee-for-service reimbursement model for PBT services in order to maintain comparison integrity.

Living cost adjustment

			Other States Rates											
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other States Average	Percent
97151	BHV ID ASSMT BY PHYS/QHP	$ 9.80	$ 18.62	$ 20.71	$ 28.00	$ 27.64	$ 60.12	$ 17.31	$ 16.94	$ 26.57	$ 35.73	$ 14.48	$ 26.61	37%
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 13.64	$ 11.92	$ 11.03	$ 15.70	$ 18.82	$ 40.08	$ 22.53	$ 11.95	$ 12.10	$ 17.66	$ 9.56	$ 17.13	80%
97154	GRP ADAPT BHV TX BY TECH	$ 6.83	$ 6.43	$ 9.37	$ 6.28	$ 10.28	$ 40.08	$ 5.66	$ 10.39	$ 2.02		$ 8.15	$ 10.96	62%
97155	ADAPT BEHAVIOR TX PHYS/QHP	$ 21.28	$ 16.76	$ 20.71	$ 28.00	$ 29.14	$ 40.08	$ 22.53	$ 26.06	$ 20.39	$ 35.73	$ 10.86	$ 25.03	85%
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 10.64	$ 8.39		$ 7.64		$ 60.12	$ 14.10		$ 3.40		$ 8.15	$ 16.97	63%

Table 17. Pediatric behavioral therapy codes compared to 10 other states adjusted for cost of living. (FY 2021-22).

Additionally, HCPF compared rates to Colorado Tricare using current Tricare rates as of July 1, 2023.

			Colorado Tricare			
Procedure Code	Procedure Description	CO HealthFirst	BCBA_D	BCBA	Assistant Behavior Analyst	Behavior Technician
97151	BHV ID ASSMT BY PHYS/QHP	$ 10.34	$ 36.73	$ 36.73	$ 36.73	
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 14.39	$ 31.25	$ 31.25	$ 20.28	$ 18.15
97154	GRP ADAPT BHV TX BY TECH	$ 7.21				
97155	ADAPT BEHAVIOR TX PHYS/QHP	$ 22.45	$ 33.22	$ 31.63	$ 26.36	
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 11.22	$ 6.76	$ 6.76	$ 6.76	$ 6.76

Table 18. Pediatric behavioral therapy codes compared to Colorado Tricare rates. (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

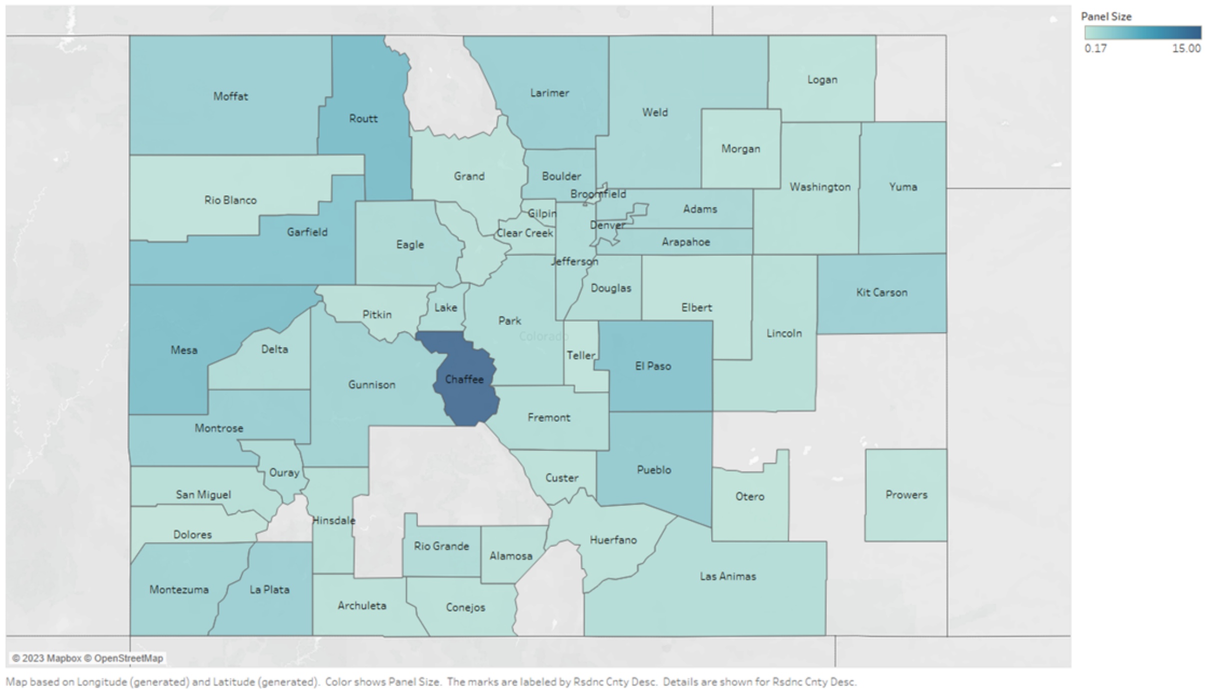

Figure 4. Pediatric behavioral therapy utilizer to provider ratio per county (FY 2021-22)

HCPF recommends removing Nebraska out of the benchmark state list since it is an extreme outlier with higher PBT rates compared to other 9 states (with rates that are 41% - 508% above other states in the benchmark cohort). The rate comparison analysis data is summarized as below after removing Nebraska.

Pediatric Behavioral Therapy Rate Benchmark Comparison		
Colorado Repriced	**Other States Repriced**	**Rate Benchmark Comparison**
$126,433,251	$139,447,581	90.7%

Table 19. Comparison of Colorado Medicaid Pediatric Behavioral Therapy service payments to those of other payers, expressed as a percentage (FY 2021-22) after removing Nebraska.

Including NE in the analysis brought Colorado's rates as a percentage of the benchmark to 78.7% versus 90.7% without Nebraska in the analysis. Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year's rate increases.

The estimated fiscal impact to Colorado Medicaid would be $13,019,386 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22 except for 97158 (which is already at 128.5%). Of the 6 procedure codes/modifier combinations analyzed in this service grouping, 5 were compared to an average of nine other states' (Florida, Massachusetts, Maryland, North Carolina, Nevada, Oregon, Texas, Utah, Washington) Medicaid rates with 1 code having no comparable rate. Individual rate ratios for PBT services, excluding NE, were 41.9% - 128.5%.

The final states used in the analysis are: Florida, Massachusetts, Maryland, North Carolina, Nevada, Oregon, Texas, Utah, and Washington. HCPF acknowledges that four of the states used in this comparison have a higher cost of living than Colorado (Massachusetts, Maryland, Oregon, Washington), while five have a lower cost of living (North Carolina, Texas, Florida, Nevada, Utah). All of the comparison states have a similar fee-for-service reimbursement model for PBT services in order to maintain comparison integrity.

Living cost adjustment

			Other States Rates										
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NV	OR	TX	UT	WA	Other States Average	Percent
97151	BHV ID ASSMT BY PHYS/QHP	$ 9.80	$ 18.62	$ 20.71	$ 28.00	$ 27.64	$ 17.31	$ 16.94	$ 26.57	$ 35.73	$ 14.48	$ 22.89	43%
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 13.64	$ 11.92	$ 11.03	$ 15.70	$ 18.82	$ 22.53	$ 11.95	$ 12.10	$ 17.66	$ 9.56	$ 14.58	94%
97154	GRP ADAPT BHV TX BY TECH	$ 6.83	$ 6.43	$ 9.37	$ 6.28	$ 10.28	$ 5.66	$ 10.39	$ 2.02		$ 8.15	$ 7.32	93%
97155	ADAPT BEHAVIOR TX PHYS/QHP	$ 21.28	$ 16.76	$ 20.71	$ 28.00	$ 29.14	$ 22.53	$ 26.06	$ 20.39	$ 35.73	$ 10.86	$ 23.35	91%
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 10.64	$ 8.39		$ 7.64		$ 14.10		$ 3.40		$ 8.15	$ 8.33	128%

Table 20.Pediatric behavioral therapy codes compared to 9 other states adjusted for cost of living. (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends increasing PBT rates to 100% of the benchmark of the other ten states and opening up a list of codes that are not currently covered by Colorado Medicaid (such as codes covering parent training).
    - Codes include: 97152, 97156, 97157, 0362T, 0373T
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $34,281,532 total funds, $17,140,766 General Fund.

HCPF Recommendations

- HCPF recommends raising all rates to 100% of the benchmark, excluding Nebraska (90.7%).
    - Nebraska is an extreme outlier with rates that are between 41% - 508% above other states in the benchmark cohort. For example, the Nebraska rate for 97155 per unit is $36.11 in 2023, which is 41% higher than the

average rate of other nine states. Its rate for 97158 per unit is $54.17, which is 508% higher than the average rate of other nine states.
  - Including NE in the analysis brought Colorado's rates as a percentage of the benchmark to 78.7% versus 90.7% without Nebraska in the analysis
    - Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year's rate increases.
- HCPF recommends leaving one procedure code (97158) with a benchmark ratio as 128.5% leave at its current rate.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $13,019,386 total funds, $6,509,693 General Fund.

Policy Justification

Given the existing waitlists for services, it is critical for HCPF to establish a reimbursement that supports this specialized workforce and expedites member access to treatment as early as possible. HCPF prioritized 97151 and 97153 to be raised to 100% based on provider feedback that these two codes would make the most impact on PBT technician workforce retention.

HCPF does not have CMS approval to cover parent training and did not receive approval when HCPF originally opened this benefit. HCPF is exploring coverage and payment options at this time and will move forward with the MPRRAC recommendation if and when approval from CMS is received.

Maternity Services

Service Description

The maternity service grouping comprises 50 procedure codes. Maternity services are any medically necessary pregnancy related service that is covered during the obstetrical period, beginning on the date of the initial visit in which pregnancy was confirmed and extending through the end of the postpartum period (generally considered ~60 days following delivery). Most maternity related services are reimbursed utilizing global maternity codes for services (including antepartum care, labor and delivery, and postpartum care) that are provided during the maternity period for uncomplicated pregnancies. Normal antepartum care includes monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. Maternity care for High-Risk Pregnancies and/or Complications of Pregnancy, where patients at risk are seen more frequently during the prenatal period

or for other medical/surgical intervention, are usually billed outside of the normal global OB package for these specific services. Any additional medically necessary visits are usually reported separately with billing codes selected to represent the appropriate level of Evaluation and Management services, as well as billed for separately identified services, such as for other medically necessary laboratory or radiologic tests performed. Maternity services were previously reviewed in the 2018 Medicaid Provider Rate Review Analysis Report.

Maternity Services Statistics	
Total Adjusted Expenditures FY 2021-22	$25,186,891
Total Members Utilizing Services in FY 2021-22	20,138
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	-0.6%
Total Active Providers FY 2021-22	1,382
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.4%

Table 21. Maternity services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for maternity services are estimated at 76.1% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Maternity Services Rate Benchmark Comparison		
Colorado Repriced	**Medicare Repriced**	**Rate Benchmark Comparison**
$28,378,660	$37,313,704	76.1%

Table 22. Comparison of Colorado Medicaid Maternity Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $8,935,044 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 50 procedure codes analyzed in this service grouping, 42 were compared to Medicare (84.0%), 2 did not have applicable repricing rates, and 6 did not have valid utilization during FY 2021-22. Individual rate ratios for maternity services were 54.8% - 124.3%.

Access to Care Analysis

The provider participation rate for maternity services is 79%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. The top 10 codes represent 96.66% of the total dollars spent on maternity services. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	59400	OBSTETRICAL CARE	$ 12,479,676	$ 13,126,685	$ 18,926,210	69.4%
2	59510	CESAREAN DELIVERY	$ 4,647,210	$ 4,885,956	$ 6,861,649	71.2%
3	59409	OBSTETRICAL CARE	$ 2,655,255	$ 2,808,269	$ 2,823,494	99.5%
4	59514	CESAREAN DELIVERY ONLY	$ 1,486,595	$ 3,246,300	$ 3,143,400	103.3%
5	59025	FETAL NON-STRESS TEST	$ 820,602	$ 1,013,424	$ 1,246,035	81.3%
6	59410	OBSTETRICAL CARE	$ 674,149	$ 708,519	$ 825,108	85.9%
7	59610	VBAC DELIVERY	$ 484,273	$ 509,049	$ 711,081	71.6%
8	59426	ANTEPARTUM CARE ONLY	$ 461,080	$ 484,446	$ 724,283	66.9%
9	59515	CESAREAN DELIVERY	$ 390,686	$ 410,714	$ 470,089	87.4%
10	59425	ANTEPARTUM CARE ONLY	$ 244,946	$ 257,341	$ 376,207	68.4%

Table 23. Top 10 codes utilized for maternity services (FY 2021-22).

HCPF identified four outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
59130	TREAT ECTOPIC PREGNANCY	$ 998	$ 1,048	$ 1,911	54.8%
59160	D & C AFTER DELIVERY	$ 36,154	$ 43,347	$ 77,443	56.0%
59300	EPISIOTOMY OR VAGINAL REPAI	$ 7,242	$ 8,543	$ 15,242	56.0%
59430	CARE AFTER DELIVERY	$ 54,158	$ 57,383	$ 98,573	58.2%

Table 24. Outliers for maternity service codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Maternity Panel Size

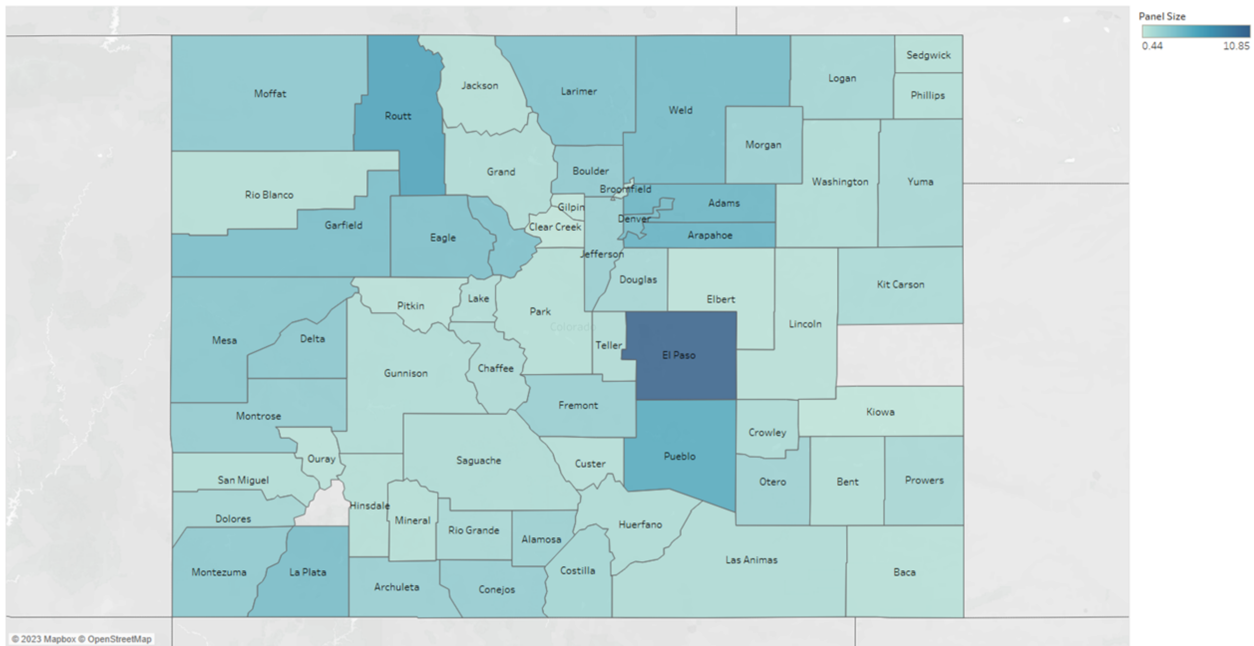

Figure 5. Maternity services utilizer to provider ratio per county (FY 2021-22)

MPRRAC Recommendations

- The MPRRAC recommends an increase of maternity rates to 100% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $8,942,246 total funds, $4,471,123 General Fund.

HCPF Recommendations

- HCPF recommends 14 out of 18 general maternity service & care codes increase to 100% of the benchmark (59160, 59300, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 59830).
  - HCPF recommends that the 4 out of 18 general maternity service & care codes that are already above 90% to remain at their current rate (59350, 59409, 59525, 59612).
- HCPF recommends 12 out of 14 pregnancy or non-viable pregnancy codes increase to 80% of the benchmark (59070, 59120, 59121, 59130, 59150, 59001, 59015, 59200, 59812, 59820, 59821, 59870).

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    - HCPF recommends that the 2 out of 14 pregnancy or non-viable pregnancy codes that are above 80% to remain at their current rate (59025, 59151).
- HCPF recommends the 10 pregnancy-related codes to remain at their current rate (59000, 59012, 59051, 59140, 59320, 59412, 59414, 59514, 59620, 59871).
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $8,494,404 total funds, $4,247,202 General Fund.

Policy Justification

Recommended increases in rates for codes focused on supporting provider's provision of specific maternity-related services, including prenatal and postpartum care. These services promote improved pregnancy outcomes, reduce maternal morbidity and mortality, and include the service codes for Global (prenatal + Labor & Delivery (L&D) + postpartum care), Partial (L&D & postpartum), and Individual (prenatal & postpartum) maternity related services. Rate increases also focused on specific reproductive care related to labor and delivery.

Abortion Services

Service Description

The abortion service grouping comprises 8 procedure codes. Per Federal/State guidelines, Health First Colorado covers abortion services if one of the three following circumstances exists: 1. A life-endangering condition for the pregnant individual and under situations of, 2. Rape, or 3. Incest. Abortion services have not been formally reviewed as a separate service until this report. Most codes from this category are also used for other reproductive healthcare services, so it has historically been reviewed as a part of maternity services. The following codes (7) had no utilization: 59855, 59841, 59850, 59851, 59852, 59856, 59857. Individual rate ratios for Abortion services were 23.0% - 57.7%.

Access to Care Analysis

The provider participation rate for abortion services is undefined due to utilization. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Due to lack of claims and Personal Health Information (PHI) HCPF was not able to publish an analysis, however, a basic comparison between the Colorado Medicaid Rate ($204.72) and the Medicare Non-Facility Rate ($256.69) can be shared.

Based on provider feedback, HCPF selected California (CA), Oregon (OR), and Illinois (IL) as a comparison for the code 59840. HCPF took the average of the 3 states (CA = $250.85; OR = $170.60; IL = $642.18) rates to find a sustainable rate for providers in Colorado (Average = $354.54).

Based on provider feedback, HCPF selected California (CA) and Illinois (IL) as a comparison for the code 59841. HCPF took the average of the 2 states (CA = $700.00; IL = $1,600.00) rates to find a sustainable rate for providers in Colorado (Average = $1,150).

MPRRAC Recommendations

- The MPRRAC recommends increasing rates closer to other states' Medicaid programs because the rates are only reviewed every three years.
- One suggestion is a targeted rate increase because there is insufficient information due to HIPAA prohibiting the disclosure of codes with less than 30 claims and concerns about how a rate increase may impact other services' rate increases:
    - Concerns about using different states as a benchmark because other factors may not be comparable to Colorado.
    - Concerns that Medicare is not used as the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is N/A.

HCPF Recommendations

- HCPF recommends raising the reimbursement rate for code 59840 (Dilation & Curettage) to $354.54.
- HCPF recommends raising the reimbursement rate for code 59841 (Dilation & Evacuation) to $1,150.00.
- The anticipated fiscal impact of HCPF's recommendations is predicted to be $325 total funds, $162 General Fund.

Policy Justification

The reimbursement rate for 59840 has never been adjusted. As a covered benefit under certain circumstances, procedure code 59840 should follow the same methodology used to evaluate rates for other covered services. The MPRRAC did not feel

comfortable with giving a definitive recommendation due to HIPAA prohibiting the disclosure of codes with less than 30 claims.

To address MPRRAC's concerns of using other states as the benchmark rather than Medicare, the majority of Medicare recipients are of an age demographic (older than 65 years old) where abortions are not commonly requested. Therefore, it is the most reasonable comparison to select other state Medicaid programs where abortion coverage is similar to Colorado's current coverage.

Dental Services

Service Description

The dental service grouping comprises 523 procedure codes (including both reviewed and excluded procedure codes). Historically, Colorado Medicaid covered dental services for children; Colorado Medicaid began covering dental services for adults in 2013. Colorado Medicaid partners with DentaQuest, which operates as an Administrative Services Only organization (ASO), to help members find a dental provider and manage dental benefits. Due to SB 22-236, HCPF was required to update the proposed service categories under review from a five-year cycle to a three-year cycle. Dental services were initially proposed for review in 2024, which would result in this category to go five years without a review, whereas under the new proposed three-year-cycle, all other Services were proposed to be reviewed within three years of their last review. After hearing from public stakeholders and providers within this service category, HCPF decided to add dental services as a partial review due to lack of data and resources, while maintaining a full review in 2024 as scheduled.

Dental services were previously reviewed in the 2018 Medicaid Provider Rate Review Analysis Report.

Dental Services Statistics	
Total Adjusted Expenditures FY 2021-22	$276,056,155
Total Members Utilizing Services in FY 2021-22	514,162
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	7.3%
Total Active Providers FY 2021-22	1,785
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.5%

Table 25. Dental Services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for dental services are estimated at 49.8% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below. The benchmark data is American Dental Association (ADA) 2022 survey data. Based on the random sample data from a nationwide group of dentists, the ADA survey data provides the national average dental fees for more than 200 commonly used dental procedure codes.

Dental Services Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$301,745,345	$606,171,602	49.8%

Table 26. Comparison of Colorado Dental Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $304,426,257 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 523 procedure codes analyzed in this service grouping, 151 were compared to the ADA Survey (28.9%), 199 did not have applicable repricing rates, and 173 did not have valid utilization during FY 2021-22. Individual rate ratios for dental services were 10.8% - 135.9%.

Access to Care Analysis

The provider participation rate for dental services is undefined. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money.

Rank	Procedure code	Procedure Description	Paid Amount	Utilization (Units)	TPL & Copayments	CO Repriced	ADA Repriced	ADA Repriced - TPL	CO as a % of Benchmark
1	D2392	Resin Based Comp Two Surfaces Posterior	$ 23,205,885	182,375	$ 319,858	$ 24,816,889	$ 44,222,290	$ 43,902,432	56.5%
2	D2391	Resin Based Comp One Surface Posterior	$ 12,844,085	128,419	$ 134,615	$ 13,716,658	$ 24,526,745	$ 24,392,130	56.2%
3	D7140	Extraction Erupted Tooth/Exposed Root	$ 12,209,393	125,216	$ 143,268	$ 13,246,079	$ 23,769,753	$ 23,626,486	56.1%
4	D2740	Crown, Porcelain/Ceramic substrate	$ 10,387,589	23,870	$ 159,003	$ 11,361,136	$ 28,956,220	$ 28,797,216	39.5%
5	D2393	Resin Base Comp Three Surface Posterior	$ 10,321,694	66,588	$ 138,236	$ 11,116,468	$ 19,631,474	$ 19,493,238	57.0%
6	D2930	Prefab Stainless Steel Crown Primary	$ 10,127,154	83,285	$ 71,702	$ 10,906,927	$ 23,616,295	$ 23,544,592	46.3%
7	D1110	Prophylaxis Adult	$ 10,096,813	245,915	$ 8,079	$ 10,622,826	$ 23,976,713	$ 23,968,633	44.3%
8	D8090	Comprehen Ortho Adult Dentition	$ 9,642,811	3,685	$ 18,830	$ 9,794,436	$ 19,994,921	$ 19,976,091	49.0%
9	D0120	Periodic oral evaluation	$ 9,425,146	422,434	$ 4,565	$ 9,947,980	$ 23,145,159	$ 23,140,594	43.0%
10	D7240	Removal Impacted Tooth Complete Bony	$ 8,865,658	34,162	$ 130,656	$ 9,788,964	$ 17,264,792	$ 17,134,136	57.1%

Table 27. Top 10 codes utilized for dental services (FY 2021-22).

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. The overall benchmark ratio for dental is only 49.8%, so the majority of codes fall under 60% of the benchmark. We found 134 out of 151 dental codes that can be identified as outliers (above 140% or below 60%), however when changing the criteria codes below 40% of the benchmark, we found 17 out of 151 as outliers.

HCPF identified 17 outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
D1354	Interim Caries Arresting Medicament Appli	$ 99,938	$ 106,957	$ 992,290	10.8%
D0190	Screening of a patient	$ 82,131	$ 87,155	$ 304,027	28.7%
D1208	Topical application of fluoride - excluding	$ 389,745	$ 408,527	$ 1,356,921	30.1%
D4212	Gingivectomy/plasty rest	$ 6,774	$ 7,118	$ 22,161	32.1%
D5650	Add Tooth to Existing Partial Denture	$ 69,250	$ 73,595	$ 220,533	33.4%
D3222	Part pulp for apexogenesis	$ 4,101	$ 4,197	$ 11,925	35.2%
D2799	Provisional crown	$ 481	$ 505	$ 1,427	35.4%
D7111	Extraction, coronal remnants	$ 410,018	$ 433,434	$ 1,202,008	36.1%
D1352	Prev resin rest, perm tooth	$ 46,819	$ 49,612	$ 135,976	36.5%
D2783	Crown 3/4 Porcelain/Ceramic	$ 4,334	$ 5,064	$ 13,652	37.1%
D9223	Deep sedation/general anesthesia – each	$ 5,906,327	$ 7,281,990	$ 19,435,698	37.5%
D2929	Prefabricated Porcelain/Ceramic Crown- P	$ 291,485	$ 321,856	$ 844,982	38.1%
D2790	Crown Full Cast High Noble Metal	$ 19,753	$ 23,856	$ 61,769	38.6%
D7450	Remov Ben Odontogenic Cyst to 1.25 cm	$ 3,048	$ 3,206	$ 8,205	39.1%
D2740	Crown, Porcelain/Ceramic substrate	$ 10,387,589	$ 11,361,136	$ 28,797,216	39.5%
D9420	Hospital/ASC call	$ 584,377	$ 621,016	$ 1,559,352	39.8%
D2750	Crown Porcelain High Noble Metal	$ 1,181,149	$ 1,303,071	$ 3,264,949	39.9%

Table 28. Outliers for dental services codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Dental Utilizer to Provider Ratio Map

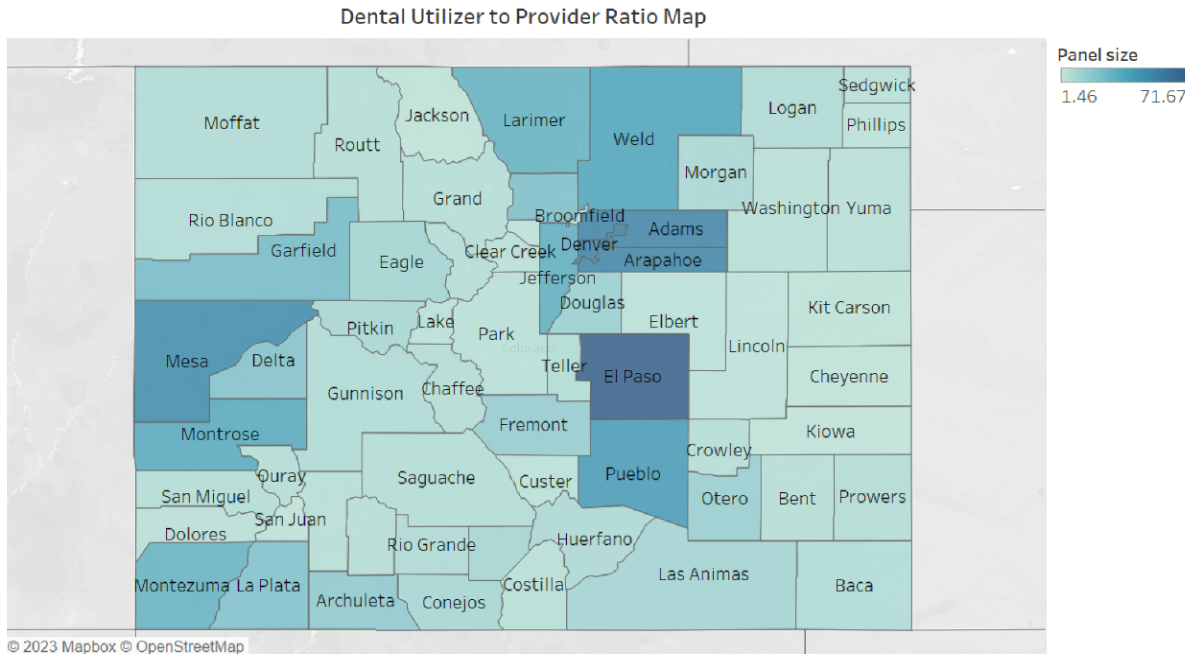

Figure 6. Dental services utilizer to provider ratio per county (FY 2021-22)

MPRRAC Recommendations

- The MPRRAC recommends that the 24 codes that the Colorado Dental Association submitted to be increased to 100% of the benchmark to have the most immediate impact on the dental community.
- The 24 identified codes are: D0120, D0140, D0150, D1110, D1120, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930, D3310, D3320, D3330, D3346, D3347, D3348, D4341, D4342, and D4910.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $104,138,137 total funds, $19,015,624 General Fund.

HCPF Recommendations

- HCPF recommends increasing preventative dental codes (D1110, D1120), endodontic codes (D3310, D3320, D3330, D3346, D3347, D3348) and periodontic codes (D4341, D4342 and D4910) to the 100% benchmark. This aligns with incentivizing dental prevention and efforts to improve member access and equity to oral health care.
- HCPF recommends the remaining thirteen codes (D0120, D0140, D0150, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930) for diagnostic services to increase to 70% of the benchmark at this time.

- HCPF recommends raising four additional preventative procedure codes: D1206, D1351, D1352, D1354 (3 codes are for sealants and 1 is for silver diamine fluoride to arrest decay) to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $85,620,023 total funds, $15,634,217 General Fund.

Policy Justification

Effective July 1, 2023 the $1500 benefit maximum for the adult dental benefit was removed, and there is currently no dollar limit to the amount of services that Adult members and Intellectual and Developmental Disabilities (IDD) members can receive under the state dental plan. The Dental team took into consideration 3 aspects of the fabrication of crowns, dentures, and/or partials needed to complete root canal treatment: the Provider network, lab (overhead) costs, and time (multiple appointments), which led to the recommendation to raise these codes to 100% of the benchmark. HCPF agreed with MPRAAC on 16 of the 24 to be increased to 100% of the benchmark. The remaining 8 of the 24, HCPF recommends an increase to 70% of the benchmark. These preventative, diagnostic, periodontal (exams, and cleanings, deep cleanings) codes are a service that are covered multiple times per year. This allows for HCPF to review and recommend an increase to 173 CDT codes.

Surgeries

The seven sub-categories of surgeries that are being examined in this report are as follows:

- Digestive System
- Musculoskeletal System
- Cardiovascular System
- Respiratory System
- Integumentary System
- Eye and Auditory System
- Other Surgeries

Surgeries Statistics	
Total Adjusted Expenditures FY 2021-22	$108,963,932
Total Members Utilizing Services in FY 2021-22	235,744
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	-3.1%
Total Active Providers FY 2021-22	14,943
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.4%

Table 29. Surgeries total expenditure and utilization data (FY 2021-22).

The surgeries service grouping comprises 5,713 procedure codes. Of the 5,173 procedure codes analyzed in this service grouping, 3,948 were compared to Medicare (76.3%), and 102 did not have applicable repricing rates, and 1,663 did not have valid utilization in FY 2021-22.

The provider participation rate for all surgery categories is 62%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers. The MPRRAC requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

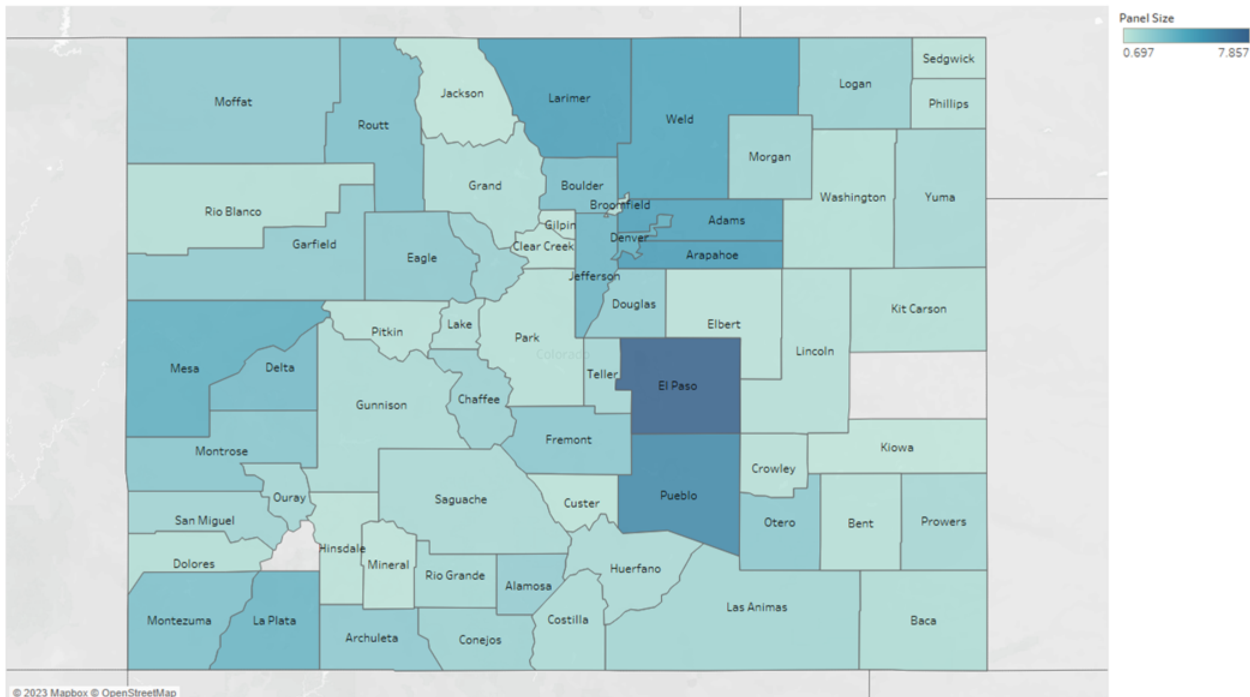

Figure 7. Surgeries (all service categories) utilizer to provider ratio per county (FY 2021-22)

HCPF identified 1,806 outliers for all surgery categories. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Figure 8. Outliers for surgeries (all service categories) over 140% (FY 2021-22).

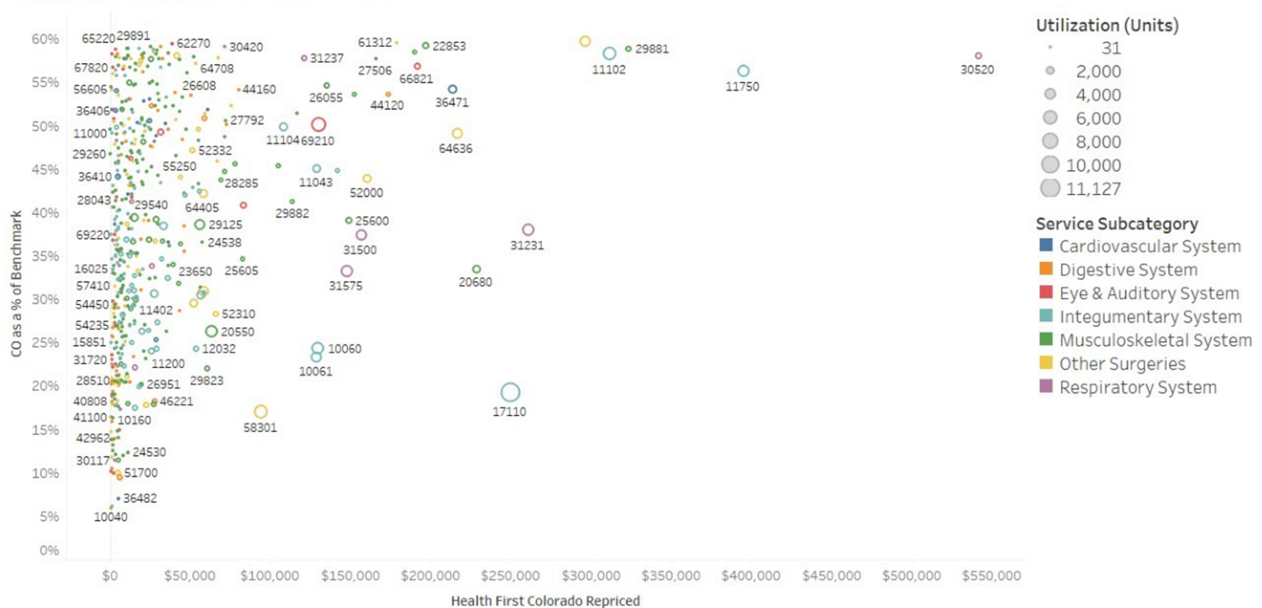

Figure 9. Outliers for surgeries (all service categories) under 60% (FY 2021-22).

The top ten codes for all surgery categories represent 19% of the total dollars spent on surgeries and are listed below:

Rank	Procedure code	Procedure Description	Service Subcategory	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	36475	ENDOVENOUS RF 1ST VEIN	Cardiovascular System	$ 3,509,446	$ 3,663,773	$ 2,315,475	158.2%
2	43239	EGD BIOPSY SINGLE/MULTIPLE	Digestive System	$ 3,135,472	$ 2,804,738	$ 2,240,528	125.2%
3	66984	XCAPSL CTRC RMVL W/O ECP	Eye & Auditory System	$ 2,782,361	$ 3,575,324	$ 3,233,924	110.6%
4	45380	COLONOSCOPY AND BIOPSY	Digestive System	$ 2,183,223	$ 2,162,143	$ 1,764,051	122.6%
5	45385	COLONOSCOPY W/LESION REMOVAL	Digestive System	$ 2,085,520	$ 2,059,813	$ 1,732,628	118.9%
6	45378	DIAGNOSTIC COLONOSCOPY	Digestive System	$ 1,653,479	$ 1,549,085	$ 1,221,953	126.8%
7	27447	TOTAL KNEE ARTHROPLASTY	Musculoskeletal System	$ 1,340,800	$ 1,706,191	$ 1,481,587	115.2%
8	64483	NJX AA&/STRD TFRM EPI L/S 1	Other Surgeries	$ 1,293,459	$ 1,093,488	$ 1,063,686	102.8%
9	49083	ABD PARACENTESIS W/IMAGING	Digestive System	$ 1,239,134	$ 1,317,225	$ 531,586	247.8%
10	47562	LAPAROSCOPIC CHOLECYSTECTOMY	Digestive System	$ 1,200,953	$ 1,193,922	$ 1,401,313	85.2%

Table 30. Top 10 codes utilized for surgeries (all service categories) (FY 2021-22).

Surgeries – Digestive System

Service Description

The digestive system surgery service grouping comprises 884 procedure codes (including both reviewed and excluded procedure codes). Digestive system surgery services involve surgical and diagnostic procedures extending from where the food enters the body to where it leaves. Digestive System Surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for the digestive system surgery services are estimated at 96.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Digestive System Surgery Rate Benchmark Comparison		
Colorado Repriced	**Medicare Repriced**	**Rate Benchmark Comparison**
$21,656,071	$22,469,116	96.4%

Table 31. Comparison of Colorado Medicaid digestive system surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $813,045 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 884 procedure codes analyzed in this service grouping, 597 were compared to Medicare (67.5%), 27 did not have applicable repricing rates, and 260 did not have any valid utilization during FY 2021-22. Individual rate ratios for Digestive System Surgery services were 6.0% - 1453.2%.

Access to Care Analysis

The provider participation rate for digestive system surgery services is 46%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 315 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

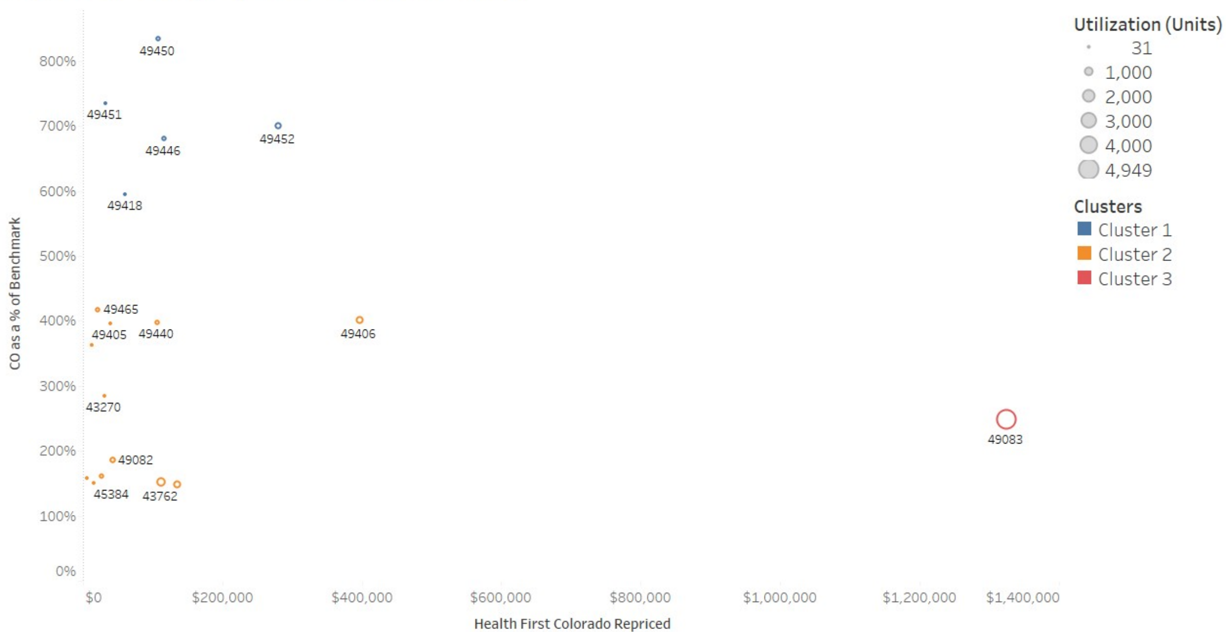

Figure 10. Outliers for digestive surgeries over 140% (FY 2021-22).

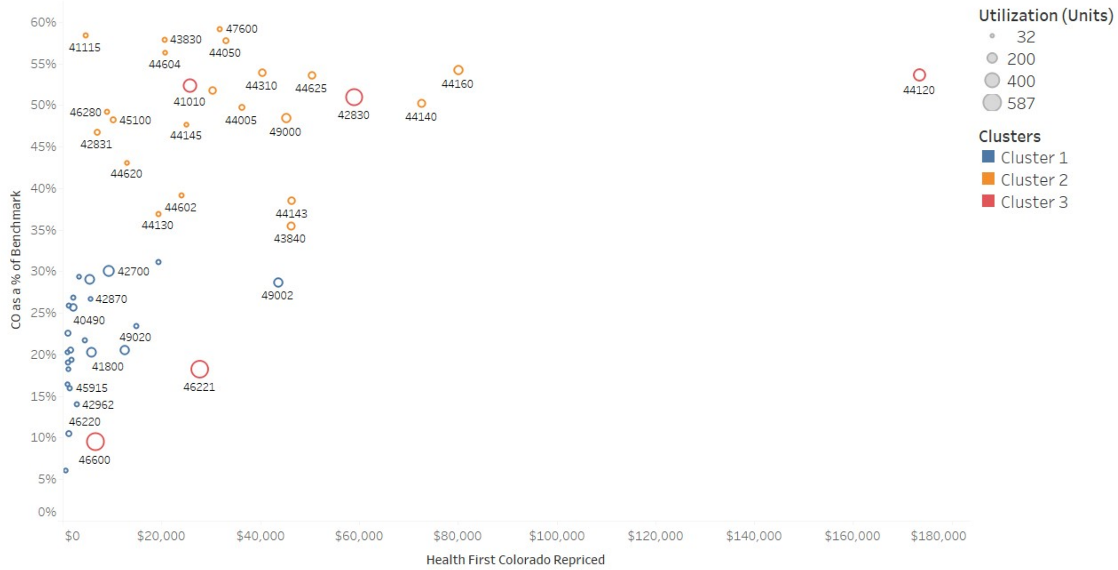

Figure 11. Outliers for digestive surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

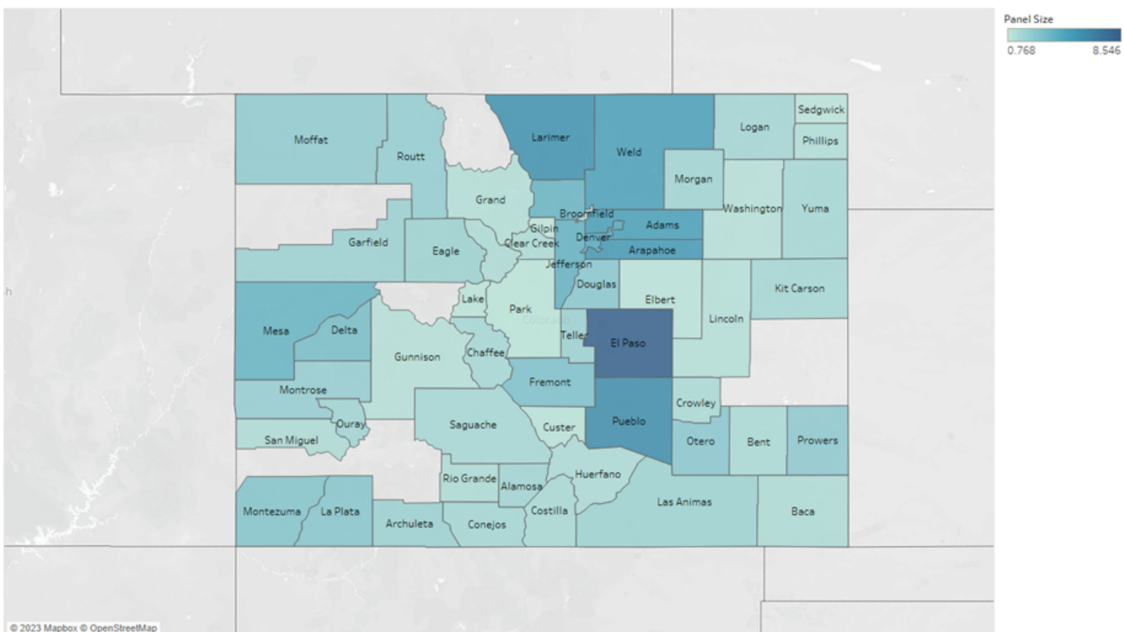

Figure 12. Digestive surgeries utilizer to provider ratio per county (FY 2021-22)

MPRRAC Recommendations

- The MPRRAC recommends keeping preventative surgery codes at 100% of the benchmark.
    - Preventative surgery codes include:
        - 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.
- For all other codes, rebalance to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be ($1,447,136) total funds, ($423,461) General Fund.

HCPF Recommendations

- HCPF recommends raising preventative surgery codes to 100% of the benchmark and keeping any preventative surgery codes over 100% at their current rate.
    - Preventative surgery codes include: 45378 through 45398
- HCPF recommends a rebalance of all other codes below 70% of the benchmark to be increased to 70%, and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be ($1,165,252) total funds, ($340,976) General Fund.

Policy Justification

HCPF's recommendation aligns with the MPRRAC recommendations and prioritizes preventative surgery codes. Rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Musculoskeletal System

Service Description

The musculoskeletal system surgery service grouping comprises 1,634 procedure codes (including both reviewed and excluded procedure codes). Musculoskeletal system surgery services involve procedures done to the locomotor system, such as spine fusions, arthroscopy, and arthroplasty. Musculoskeletal system surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for musculoskeletal system surgery services are estimated at 66.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Musculoskeletal System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$24,538,187	$36,927,306	66.4%

Table 32. Comparison of Colorado Medicaid Musculoskeletal System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $12,389,119 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 1,634 procedure codes analyzed in this service grouping, 1,240 were compared to Medicare (75.9%), 20 did not have applicable repricing rates, and 374 did not have valid utilization during FY 2021-22. Individual rate ratios for Musculoskeletal System Surgery services were 6.2% - 1734.1%.

Access to Care Analysis

The provider participation rate for musculoskeletal system surgery services is 53%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 708 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Musculoskeletal Surgery Outliers over 140%

Figure 13. Outliers for musculoskeletal surgeries over 140% (FY 2021-22).

Musculoskeletal Surgery Outliers Under 60%

Figure 14. Outliers for musculoskeletal surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - Musculoskeletal Systems

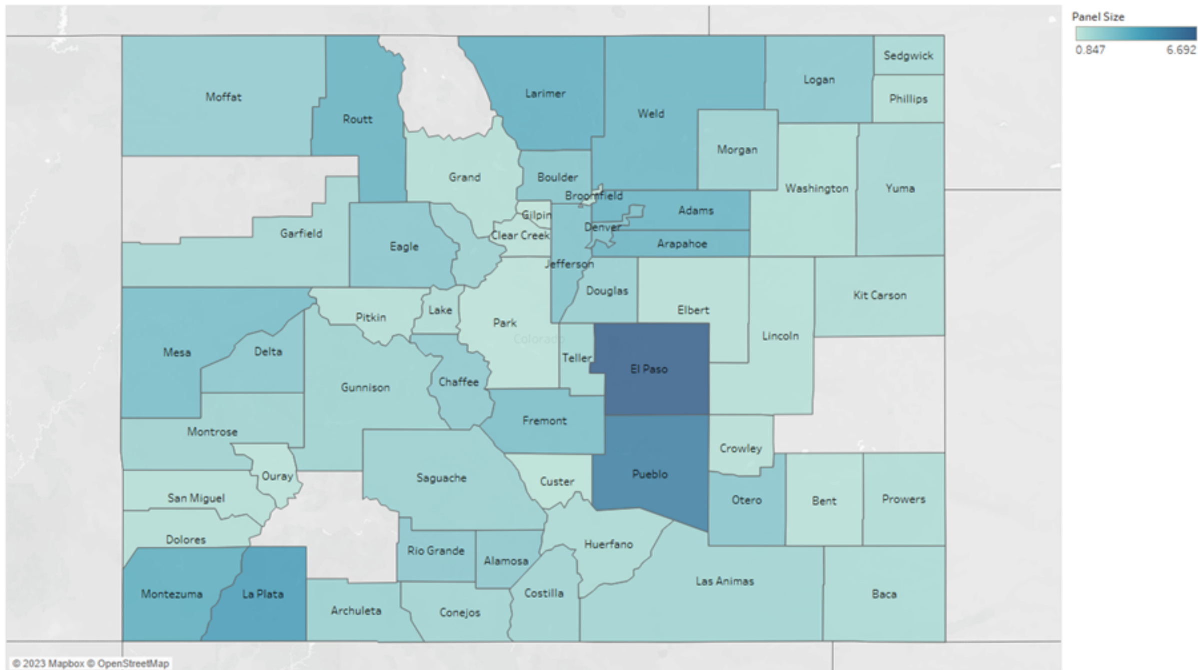

Figure 15. Musculoskeletal surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $5,003,658 total funds, $1,464,171 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $3,732,671 total funds, $1,092,254 General Fund.

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Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The musculoskeletal system surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Cardiovascular System

Service Description

The cardiovascular system surgery service grouping comprises 767 procedure codes. Cardiovascular system surgery services involve procedures related to the heart, veins, and arteries. Cardiovascular system surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for cardiovascular system surgery services are estimated at 162.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Cardiovascular System Surgery Rate Benchmark Comparison		
Colorado Repriced	**Medicare Repriced**	**Rate Benchmark Comparison**
$17,675,644	$10,881,937	162.4%

Table 33. Comparison of Colorado Medicaid Cardiovascular System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be ($6,793,706) total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 767 procedure codes analyzed in this service grouping, 446 were compared to Medicare (58.1%), 12 did not have applicable repricing rates, and 309 did not have valid utilization during FY 2021-22. Individual rate ratios for Cardiovascular System Surgery services were 5.6% - 1302.4%.

The repricing methodology of cardiovascular surgery service which MPRRAC committee's recommendations are based is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. These repricing amounts and benchmark ratio are listed in the Table 31 above. However, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service. Based on the Medicare non-facility

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fee schedule, the benchmark ratio of cardiovascular system surgery services decreased from 162.4% to 74.8%. The CO repriced amount is $17,683,989 and the Medicare repriced is $23,656,358. The ratio range for this new repricing method is 2.2% - 162.9%. The reason why the Medicare repricing methodology was changed for the cardiovascular system surgery services was because this category has the lowest provider participation ratio among all surgery services (40%).

Access to Care Analysis

The provider participation rate for cardiovascular system surgery services is 40%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 123 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

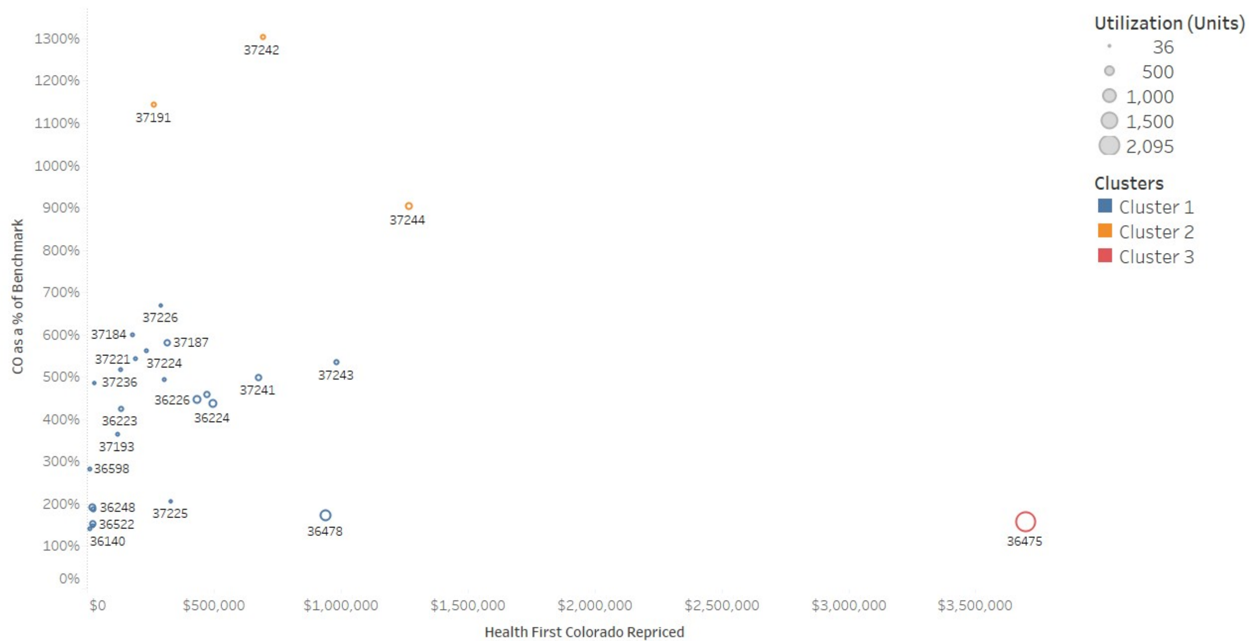

Figure 16. Outliers for cardiovascular surgeries over 140% (FY 2021-22).

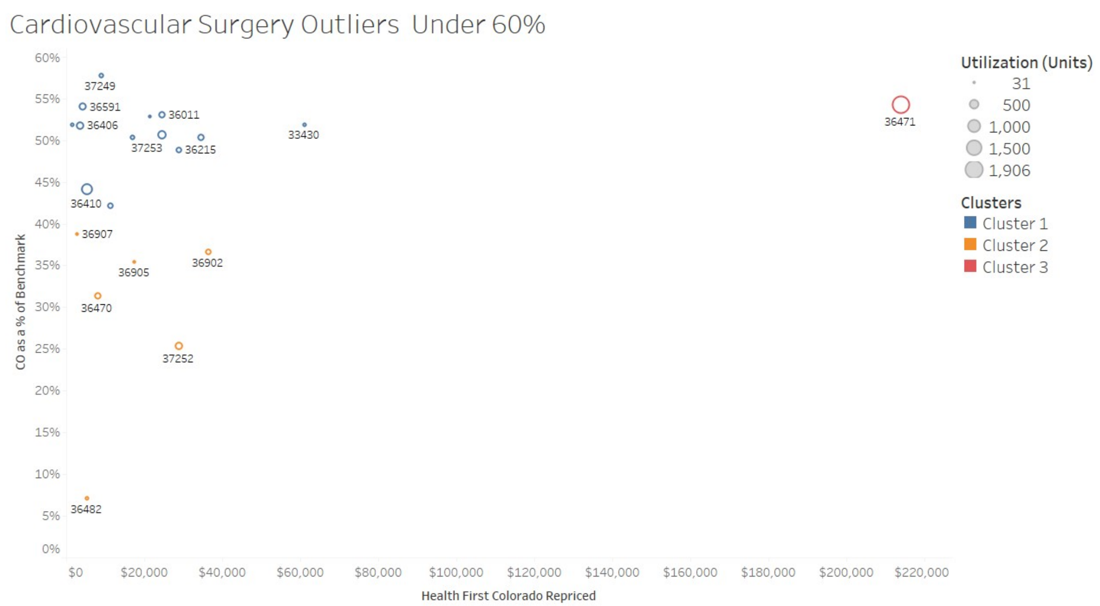

Figure 17. Outliers for cardiovascular surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

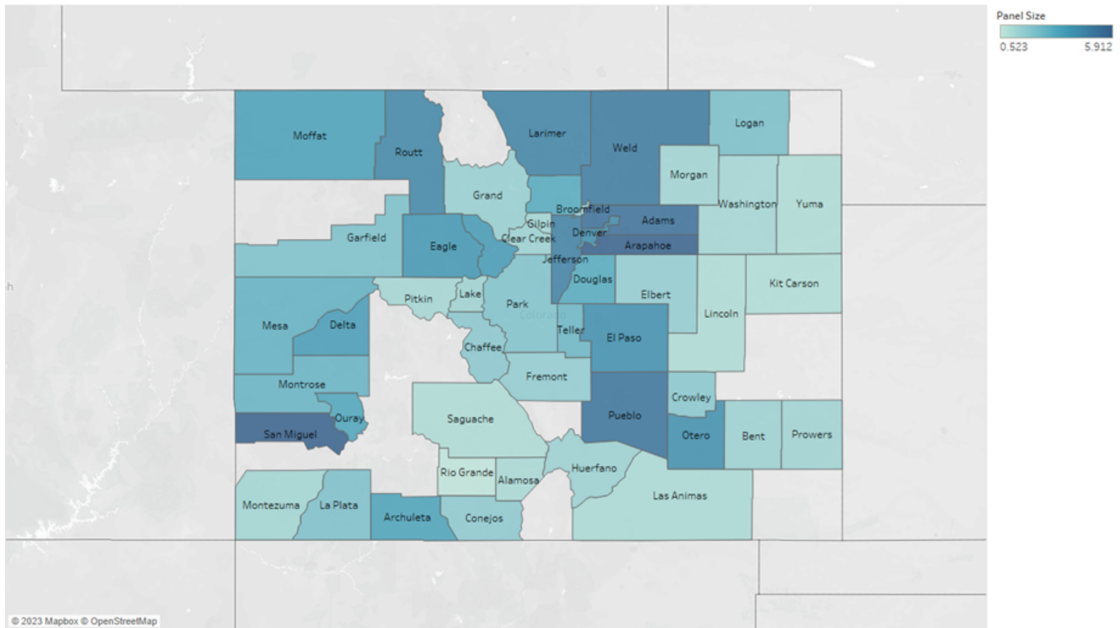

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Figure 18. Cardiovascular surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be ($7,723,131) total funds, ($2,259,943) General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 125% of the benchmark to be reduced to 125% using only non-facility Medicare rates as the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $2,842,496 total funds, $831,772 General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The cardiovascular surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries – Respiratory System

Service Description

The respiratory system surgery service grouping comprises 310 procedure codes. Respiratory system surgery services involve procedures related to the diagnostic evaluation and invasive surgeries of the nose, trachea, bronchi, lungs, and pleura. Respiratory system surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for respiratory system surgery services are estimated at 82.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Respiratory System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison

$5,026,476	$6,092,153	82.5%

Table 34. Comparison of Colorado Medicaid Respiratory System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $1,065,677 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 310 procedure codes analyzed in this service grouping, 202 were compared to Medicare (65.2%), 6 did not have applicable repricing rates, and 102 did not have valid utilization for FY 2021-22. Individual rate ratios for Respiratory System Surgery services were 6.4% - 823.3%.

Access to Care Analysis

The provider participation rate for respiratory system surgery services is 51%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 88 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending

on.

Figure 19. Outliers for respiratory surgeries over 140% (FY 2021-22).

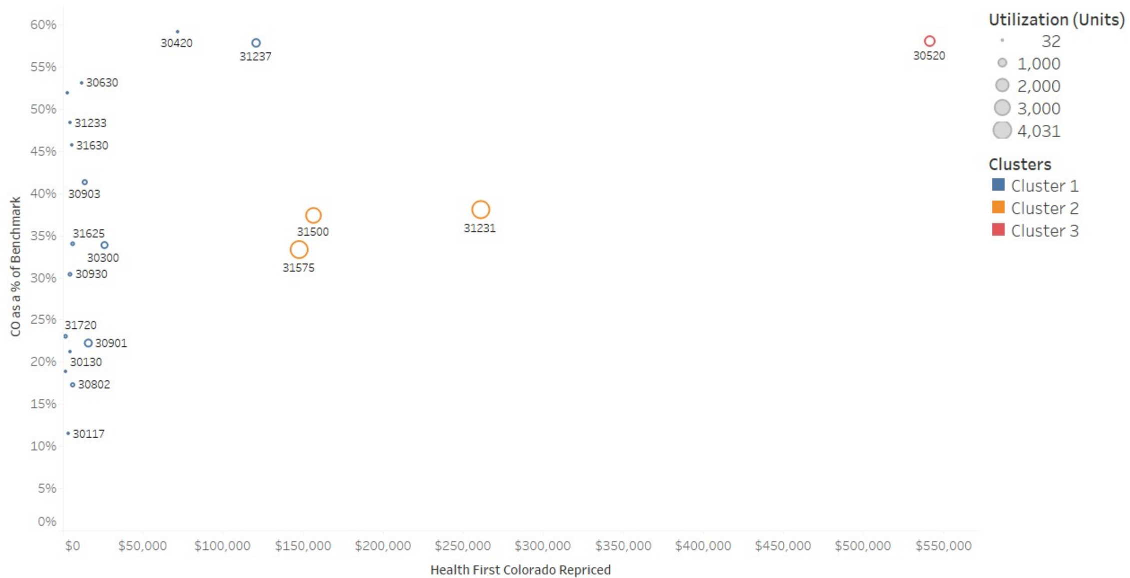

Figure 20. Outliers for respiratory surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

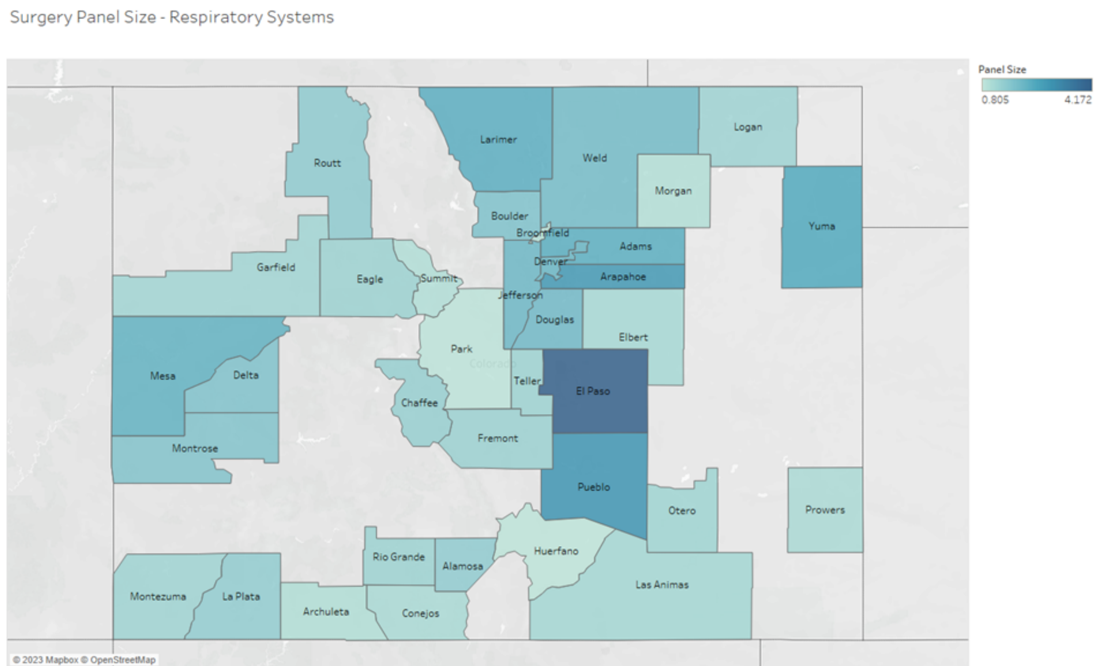

Figure 21. Respiratory surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $180,879 total funds, $52,929 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be ($223,909) total funds, ($65,520) General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The respiratory system surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the

Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Integumentary System

Service Description

The integumentary system surgery service grouping comprises 414 procedure codes. Integumentary system surgery services involve procedures of the skin and breast. Integumentary system surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for integumentary system surgery services are estimated at 63.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Integumentary System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$10,310,353	$16,229,309	63.5%

Table 35. Comparison of Colorado Medicaid Integumentary System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $5,918,956 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 414 procedure codes analyzed in this service grouping, 330 were compared to Medicare (79.7%), 7 did not have applicable repricing rates, and 76 did not have valid utilization during FY 2021-22. Individual rate ratios for Integumentary System Surgery services were 4.7% - 470.9%.

Access to Care Analysis

The provider participation rate for integumentary system surgery services is 60%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 171 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Figure 22. Outliers for integumentary surgeries over 140% (FY 2021-22).

Figure 23. Outliers for integumentary surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

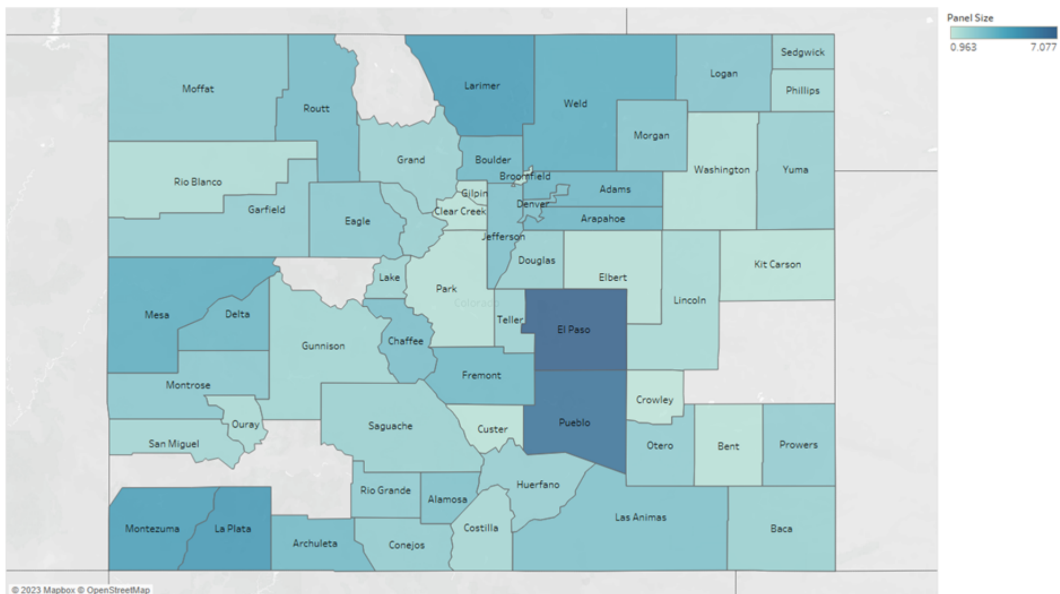

Figure 24. Integumentary surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $3,216,801 total funds, $941,300 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
  - HCPF recommends 1 preventative code (17380) to increase to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $2,081,628 total funds, $609,126 General Fund.

Policy Justification

Since HCPF's recommendation is to prioritize preventative surgery codes. In addition to recommending rebalancing codes above and below benchmark rates to fit within budget restrictions and provide a more equitable distribution of available funding, HCPF recommends increasing one preventative code to 100%.

Surgeries - Eye and Auditory System

Service Description

The eye and auditory system surgery service grouping comprises 370 procedure codes. Eye and auditory systems surgery services involve surgeries pertaining to the eye, including the ocular muscles and eyelids, and ears. Eye and auditory system surgery services were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for eye and auditory system surgery services are estimated at 95.0% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Eye and Auditory System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
$8,529,687	$8,975,288	95.0%

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Table 36. Comparison of Colorado Medicaid Eye and Auditory System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $445,601 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 370 procedure codes analyzed in this service grouping, 249 were compared to Medicare (67.3%), 9 did not have applicable repricing rates, and 112 did not have valid utilization during FY 2021-22. Individual rate ratios for eye and auditory system surgery services were 7.8% - 653.8%.

Access to Care Analysis

The provider participation rate for eye and auditory system surgery services is 50%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 103 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

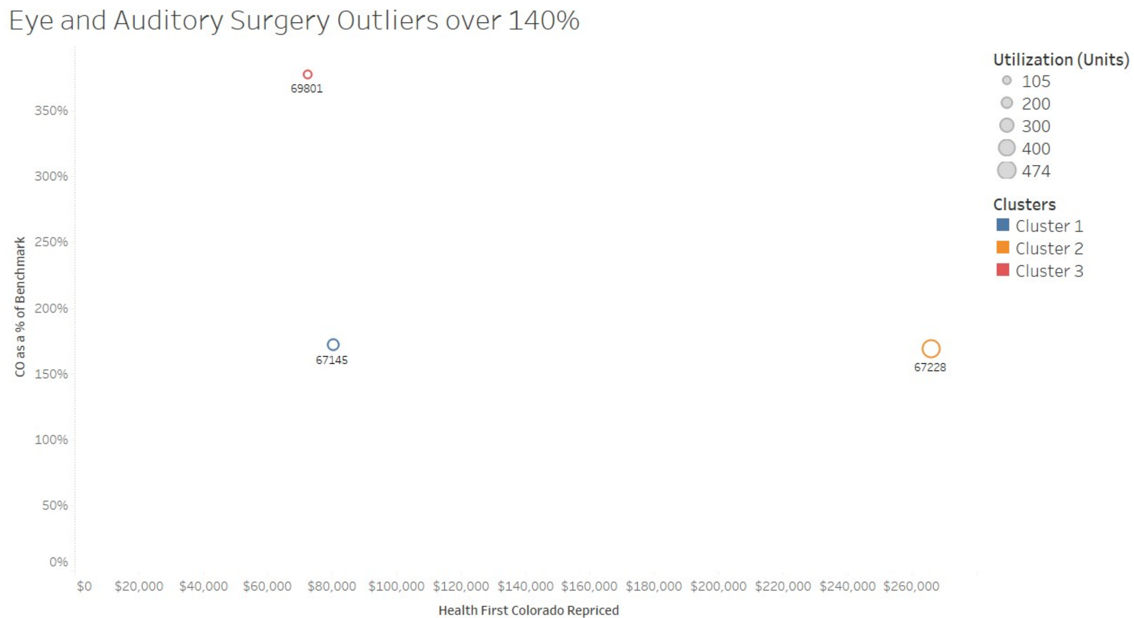

Figure 25. Outliers for eye and auditory surgeries over 140% (FY 2021-22).

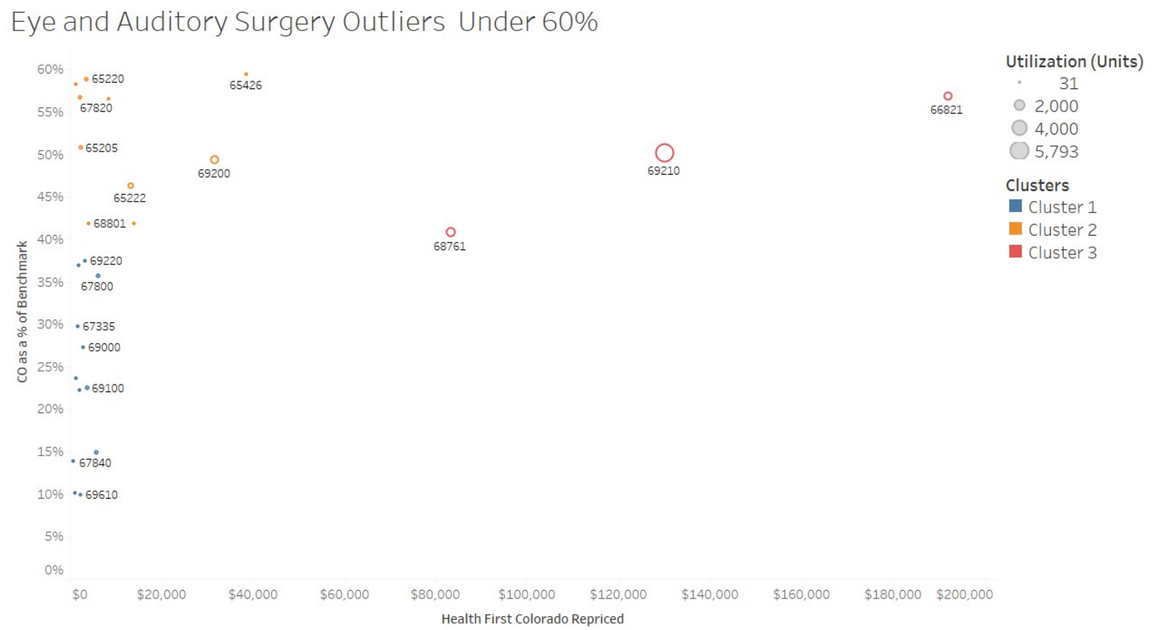

Figure 26. Outliers for eye and auditory surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

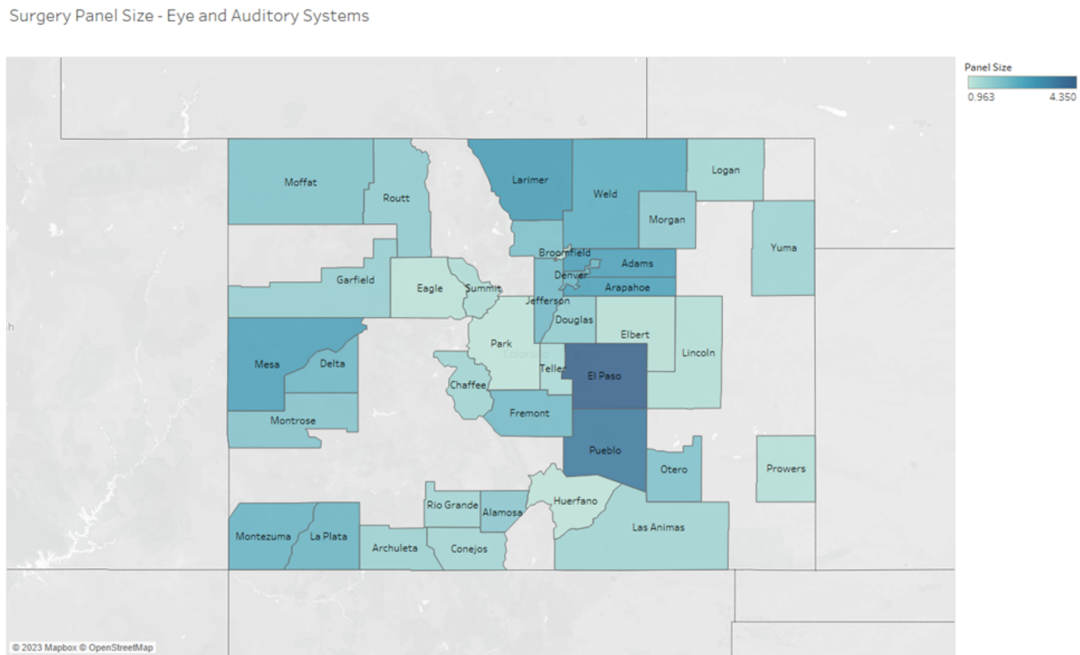

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Figure 27. Eye and auditory surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be ($176,581) total funds, ($51,671) General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be ($383,945) total funds, ($112,350) General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The eye and auditory surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Other

Service Description

The other surgery service grouping comprises 1334 procedure codes. This category includes procedures which are considered surgeries but are not included in any of the other surgical categories covered in this report. Services under "other surgeries" are as follows: endocrine system, female genital system, male genital system, intersex surgery, and urinary system. These surgery categories have been added to the rate review cycle since surgeries were previously reviewed in the 2017 Medicaid Provider Rate Review Analysis Report.

Rate Comparison Analysis

On average, Colorado Medicaid payments for other surgery services are estimated at 78.2% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Other Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison

$21,227,515	$27,145,528	78.2%

Table 37. Comparison of Colorado Medicaid Other Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be $5,918,013 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 1334 procedure codes analyzed in this service grouping, 883 were compared to Medicare (66.2%), 21 did not have applicable repricing rates, and 430 did not have valid utilization during FY 2021-22. Individual rate ratios for Other Surgery services were 2.5% - 1335.2%.

Access to Care Analysis

The provider participation rate for other surgery services is 54%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See Appendix D for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 298 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Figure 28. Outliers for other surgeries over 140% (FY 2021-22).

Figure 29. Outliers for other surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

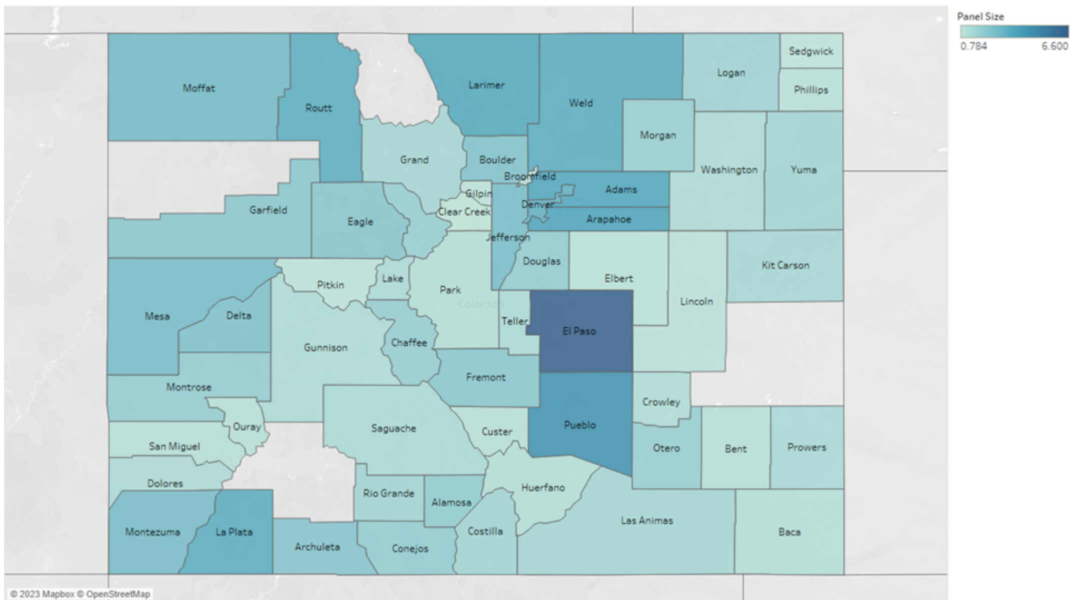

Figure 30. Other surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $1,809,649 total funds, $529,540 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be $505,358 total funds, $147,878 General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The other surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Co-Surgery

HCPF reviewed its co-surgery policy in response to provider feedback regarding reimbursement for certain procedures when performed as co-surgeries. Providers expressed concern that the limited scope of co-surgery reimbursement does not allow the flexibility for two surgeons to collaborate on highly complex procedures where the skills of two surgeons are necessary. This can limit access to high quality care or result in providers performing services that cannot be reimbursed.

Currently HCPF only allows co-surgery reimbursement for CPT codes which CMS has assigned a co-surgery indicator of '2'. We are proposing to expand the list of surgeries for which the Department allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes approximately 2500 additional codes. This will align HCPF more closely with Medicare's co-surgery policy and create clarity for providers.

MPRRAC Recommendation

- The MPRRAC did not receive data on Co-Surgery, therefore did not make a recommendation.

HCPF Recommendation

- HCPF recommends to expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes 2,469 codes.
- The anticipated fiscal impact of the co-surgery recommendation is about $1,759,670 total funds, $514,915 General Fund.

Policy Justifications

HCPF reviewed its co-surgery policy in response to provider feedback regarding reimbursement for certain procedures when performed as co-surgeries. Providers expressed concern that the limited scope of co-surgery reimbursement does not allow the flexibility for two surgeons to collaborate on highly complex procedures where the skills of two surgeons are necessary. This can limit access to high quality care or result in providers performing services that cannot be reimbursed.

Currently HCPF only allows co-surgery reimbursement for CPT codes which CMS has assigned a co-surgery indicator of '2'. By expanding the list to include all CPT codes which CMS has assigned a co-surgery indicator of '1', this will align HCPF more closely with Medicare's co-surgery policy and create clarity for providers.

Appendices

Appendix A – Cycle 1 Year 1 Methodologies and Data

Provides explanations of methodologies and data used in this report.

Appendix B1 - Base Data Summary

Provides more detailed rate comparison benchmark summaries and results that were introduced and discussed in the narrative.

Appendix B2 - Rate Ratios

B2(a) – Anesthesia
B2(b) - Ambulatory Surgical Centers (ASC)
B2(c) – FFS Behavioral Health Services
B2(d) – Maternity
B2(e) - Abortion
B2(f) - Pediatric Behavioral Therapy
B2(g) – Dental
B2(h) - Surgery

Appendix C - Fiscal Impact

The method to calculate a fiscal impact number for a service grouping has two steps. First, within the same service grouping, subtract the repriced Colorado Medicaid expenditure amount of each impacted procedure code from the adjusted expenditure amount which is based on the targeted ratio of the benchmark recommended by MPRRAC or the department. Second, sum up the total fiscal impact amount for the whole service grouping.

Appendix D - Stakeholder Feedback

Contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings

Appendix E - Glossary and County Reference Map

Provides explanations for common terms used throughout the 2023 Medicaid Provider Rate Review Analysis Report, as well as a reference map of counties in Colorado by classification.

Appendix A – Cycle 1 Year 1 Methodologies and Data

Provides explanations of methodologies and data used in this report.

Executive Summary

The Colorado Department of Health Care Policy and Financing (HCPF) contracted with the actuarial firm **CBIZ Optumas (Optumas)** and worked collaboratively to compare Colorado Medicaid provider rates to Medicare or other comparable rates (e.g., other states' Medicaid rates).

The following services were reviewed by **Optumas** as part of the 2023 Medicaid Provider Rate Review Analysis Report:

- Anesthesia
- Ambulatory Surgical Centers (ASC)
- Fee-for-Service Behavioral Health Services (FFS BH)
- Maternity Services
- Abortion Services
- Pediatric Behavioral Therapy (PBT)
- Dental Services
- Surgeries:
    - Digestive System
    - Musculoskeletal System
    - Cardiovascular System
    - Respiratory System
    - Integumentary System
    - Eye & Auditory System
    - Other
    - Co-Surgery

The work performed on Cycle 1 Year 1 services was comprised of the following analyses:

1) Data validation
2) Rate crosswalk
3) Utilization adjusted rate comparison

The data validation process includes:

- Volume checks over time to determine completeness and reliability of data; and
- Determination of relevant utilization base and appropriate exclusions

The rate comparison benchmark analysis for July 1, 2021 – June 30, 2022 (FY 2022) compares Colorado Medicaid's latest fee schedule's estimated reimbursement with the estimated reimbursement of the overall benchmark(s). The rate comparison benchmark analysis considers Medicare rates as the comparator. In prior years, and the current year, when comparable Medicare rates were not available, an average rate from a selected group of other states was used.

All else being equal, if Colorado Medicaid were to reimburse at 100.00% of the overall benchmark, expenditures for FY 2022 would reflect the estimated total fund impact summarized in **Table 1**.

Table 1. Colorado as a Percent of the Medicare/Other States Benchmark and Estimated FY 2022 Fund Impact

Service Group	Colorado Repriced	Medicare Repriced	Colorado as a Percent of Medicare	Estimated FY 2022 Total Fund Impact
Anesthesia	$36,268,689	$26,370,722	137.5%	$(9,897,967)
Ambulatory Surgical Centers (ASC)*	$10,832,192	$20,265,101	53.5%	$9,432,909
Fee-for-Service Behavioral Health Services (FFS BH)	$18,175,906	$18,732,206	97.0%	$556,300
Maternity Services	$28,378,660	$37,313,704	76.1%	$8,935,044
Abortion Services	NA	NA	NA	NA
Pediatric Behavioral Therapy (PBT):				
Method 1: Including Nebraska	$126,433,251	$160,714,783	78.7%	$34,281,532
Method 2: Excluding Nebraska	$126,433,251	$139,447,581	90.7%	$13,019,386
Dental Services	$301,745,345	$606,171,602	49.8%	$304,426,257
Surgeries:				
Digestive System	$21,656,071	$22,469,116	96.4%	$813,045
Musculoskeletal System	$24,538,187	$36,927,306	66.4%	$12,389,119
Cardiovascular System**	$17,675,644	$10,881,937	162.4%	($6,793,706)
Respiratory System	$5,026,476	$6,092,153	82.5%	$1,065,677
Integumentary System	$10,310,353	$16,229,309	63.5%	$5,918,956
Eye & Auditory System	$8,529,687	$8,975,288	95.0%	$445,601
Other	$21,227,515	$27,145,528	78.2%	$5,918,013
Co-Surgery	NA	NA	NA	$1,759,670

The comparison for Ambulatory Surgical Centers uses the primary line of each encounter only. In general, Colorado Medicaid only reimburses for the most expensive ASC service on an encounter, but Medicare pays for additional ASC services, though sometimes at a reduced rate.

****Here these repriced amounts, benchmark ratio and fund impact for cardiovascular surgery service is based on the repricing methodology which is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. In addition, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service.***

Data Validation

The Department initially provided three years (January 2019 – December 2021) of eligibility data and fee-for-service (FFS) claims data to **Optumas**. For the Rate Comparison analysis, the Department sought to use FY 2022 for the benchmark comparison, so an additional three months of data was provided (July 2022 – September 2022). The data validation process included utilization and dollar volume summaries over time which were validated against the expectations of the Department and Optumas based on prior analyses to identify potential inconsistencies. In addition, a frequency analysis was performed to examine valid values

appearing across all fields contained in the data. Overall, results of this process suggested that the FY 2022 data for each service was reliable.

Next, the data was reviewed to determine the relevant utilization after accounting for applicable exclusions. The exclusion criteria adhere to the general guidelines set forth in the Rate Review Schedule:[1]

- Claims attributed to members that are non-TXIX Medicaid eligible, i.e., Child Health Plan *Plus* (CHP+) program;
- Claims attributed to members with no corresponding eligibility span; and
- Claims associated with members enrolled in Medicaid and Medicare (dual membership).

Furthermore, for the rate comparison benchmark, the validation process included additional exclusions:

- Procedure codes that are on the Colorado fee schedule as “manually priced” or “not a benefit” or were not found on the schedule, which are reflected as “No Medicaid rate.”
- Procedure codes that do not have a comparable Medicare rate, which are reflected as “No Medicare rate.”
- If both prior cases are true, then the line is reflected as “No Medicare/Medicaid rate.”
- If there is no appropriate benchmark rate from other states or ADA fee schedule, the line is reflected as “No other state rate.”
- If a procedure code had no valid utilization during FY22, the line is reflected as “No valid utilization.”

The list of procedure codes that were excluded from this analysis are shown in **Table 2(a)** below.

Table 2(a). List of Procedure Codes Excluded
See the attached workbook with Table 2(a).

Except for Ambulatory Surgical Centers (ASC), which use groupers instead of procedure code for analysis, the number of excluded procedure codes for each service group is shown in **Table 2(b)** below.

[1] See the Rate Review Schedule on the Department’s Medicaid Provider Rate Review Advisory Committee (MPRRAC) website.

Table 2(b). Count of Procedure Codes Excluded

Service Group	No Medicaid Rate	No Medicare Rate	No Medicaid or Medicare Rate	No other state rate	No ADA rate or no Medicaid/ ADA rate	No valid utilization
Anesthesia	35	4	0	0	0	6
Maternity Services	0	2	0	0	0	6
Pediatric Behavioral Therapy (PBT) - same for two methods	0	0	0	1	0	0
Abortion	0	0	0	0	0	7
Dental	23	0	0	0	176	173
Surgery	4	42	56	0	0	1,663

Services were priced to the Colorado Medicaid fee schedules at the procedure code level. The summary of exclusions from the FY 2022 base data can be found in **Appendices B1(a) - B1(g)**.

FY 2022 claims data were selected as the base data of the repricing analysis because they yield an annualized result derived from the most recent experience. There is an inherent processing lag in claims between the time a claim is incurred and when it is billed, i.e., a concept referred to as claims runout. Claims rendered in any given month can take weeks or months to be reported in the claims system. The claims data for Cycle 1 Year 1 services were provided with three months of claims runout. The raw claims data reflects the vast majority of FFS experience for Cycle 1 Year 1 services in FY 2022 and an IBNR (Incurred but not reported) analysis was not performed.

After the data validation step, the rate comparison benchmark analysis was performed.

Rate Comparison Benchmark Analysis

The first step in the rate comparison benchmark analysis was a repricing exercise using the most recent Colorado Medicaid fee schedule with rates effective July 1, 2022. However, a new repricing based on the July 1, 2023, Colorado Medicaid fee schedule was implemented in July 2023.

Anesthesia rates were reviewed by procedure code to obtain a Colorado repriced amount. No modifiers were considered when pulling rates from the Medicare physician fee schedule because modifiers are not considered when repricing Anesthesia using the Colorado Medicaid physician fee schedule. The Medicare fee schedule was then used to identify comparable rates, reference publicly available documentation on reimbursement policy, and analyze relevant fee schedules specific to Colorado to produce a more valid comparison.[2]

ASC procedure codes were first grouped into ASC groups A01 through A11. The intensity of service goes up from A01 and the rate for each group also increases. The rates range from

[2] The payment rate comparison is influenced by the choice of fee schedule since Colorado-specific Medicare rates are higher than those derived from unadjusted national relative value units. All Medicare rates and relevant information were effective calendar year 2023.

$280.02 for A01 to $3,574.20 for A11. Colorado Medicaid, in general, covers payment for the highest intensity service on any given encounter, which is different from the methodology that Medicare uses to pay ASC claims. For Medicare claims, the highest intensity service is covered according to the fee schedule, and subsequent lines with ASC services are paid, potentially, at a discounted rate. For this reason, the results of the rate comparison for ASC are reflective of only the primary line on any encounter being repriced for both Medicaid and Medicare. Because Colorado Medicaid does not have different rates for ASC based on modifiers, only the procedure codes were used and cross walked to ASC groups.

FFS BH procedure codes were grouped into two groups: therapy codes (13 codes) and assessment codes (18 codes). All FFS BH rates were reviewed by procedure code and repriced using the Colorado Medicaid physician fee schedule. Here the rate for a FFS BH procedure code without modifier on the Colorado Medicaid physician fee schedule was selected as the CO Medicaid rate, excluding the same procedure code with a specified modifier. 30 procedure codes were compared with Medicare rates and one code was compared with the average rate of other nine states (Florida, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington). For Medicare rates, non-facility fees were selected as default.

Maternity rates were reviewed by procedure code to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid physician fee schedule unless there was a note on the fee schedule to "See Prenatal Plus Fee Schedule." However, the procedure codes for rates on the Prenatal Plus schedule are not rates covered by Medicare, so those were excluded from the rate comparison. For Medicare rates, different fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data.

Although a Medicare rate is available to be used as the benchmark rate for two abortion procedure codes, this review used the average rates from three (California, Oregon and Illinois) or two other states (California and Illinois) as the benchmark rate because the Medicare base rate was too low.

PBT rates were reviewed by procedure code and to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid physician fee schedule. However, a transformation was conducted to the procedure code 97151 (without modifier) as it was a flat rate, while other states use a 15-minutes unit base. The rate was then divided by 32 since it was designed originally based on an 8-hour service assumption. There are two methods for the PBT analysis. The first method is with ten states including Nebraska. Ten states (Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington) were selected as the comparison states based on recommendations from internal subject matter experts and external providers. In addition, both Colorado Medicaid rates and ten states' PBT rates were adjusted based on the current Cost of Living Index, which was sourced from C2ER (Council for Community & Economic Research), with 2023 Q1 as the time period). Finally, the adjusted repriced Colorado Medicaid PBT rates were compared with the adjusted averaged rates from ten states. The second method is with nine states excluding Nebraska. HCPF recommended removing Nebraska out of the benchmark state list since its PBT rates were an extreme outlier compared to the other 9 states. The final states used in the second method are: Florida, Massachusetts, Maryland,

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North Carolina, Nevada, Oregon, Texas, Utah, and Washington. The remaining steps followed those used in the first method.

Dental rates were reviewed by procedure code to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid dental fee schedule. American Dental Association (ADA) survey 2022 data was used as the benchmark rate. 151 out of 523 Colorado Medicaid dental procedure codes were compared with ADA survey rates.

All surgery rates were reviewed by procedure code and repriced using the Colorado physician fee schedule, similar to repricing for Maternity. For all surgeries, Medicare's base rate, which is listed by procedure code, includes a breakout for facility versus non-facility and is considered to compare an appropriate rate. In addition, there was a supplemental analysis for cardiovascular surgeries, by using Medicare's non-facility fees as the comparison base.

In previous cycles when a comparable Medicare rate could not be found, an average of other states' rates was used. This left some data for which a comparable rate could not be found under the Cycle 1 Year 1 service categories. The utilization in the base data associated with these non-comparable claims were excluded for the remainder of the rate comparison benchmark analysis.

The final step consisted of applying the base utilization to Colorado Medicaid's latest available fee schedule, as well as the matched rates from Medicare. This entailed multiplication of utilization and the corresponding rates from each source, followed by subtraction of third-party liability (TPL) and copayments, to calculate the estimated total dollars that would theoretically be reimbursed by each source.

The range of ratios derived from comparing Health First Colorado rates to those of Medicare is shown by the service group in **Table 3**.

Table 3. Rate Ratio Ranges

Service Group	Medicare/Other States
Anesthesia	129% - 271.7%
Ambulatory Surgical Centers (ASC)*	26.2% - 79.5%
FFS BH	51.1% - 401.3%
Maternity Services	54.8% - 124.3%
Abortion	23.0% - 57.7%
PBT - Method 1: Including Nebraska	36.0% - 84.8%
PBT - Method 2: Excluding Nebraska	41.9% - 128.5%
Dental	10.8% - 135.9%
Surgery - Digestive System	6.0% - 1453.2%
Surgery - Musculoskeletal System	6.2% - 1734.1%
Surgery - Cardiovascular System	5.6% - 1302.4%
Surgery - Respiratory System	6.4% - 823.3%
Surgery - Integumentary System	4.7% - 470.9%
Surgery - Eye & Auditory System	7.8% - 653.8%
Surgery - Other	2.5% - 1335.2%

As an example, the top figure in **Table 3** can be interpreted to mean that when comparing Anesthesia Services to Medicare rates by procedure code, the Colorado Medicaid rates were anywhere from 129% to 271.7% of the Medicare rate.

Estimated expenditures were only compared for the subset of Cycle 1 Year 1 services that are common between Colorado Medicaid and Medicare except for PBT, abortion, and dental services. In other words, if no comparable rate could be found for a specific service offered in Colorado Medicaid, then the associated utilization and costs were not shown within the comparison results.

In the service-specific payment comparison sections of the narrative that follow, more detailed information can be found on the Medicare portions of the rate comparison benchmark.

Anesthesia Payment Comparison

There is a matching Medicare rate for over 99.2% of the Anesthesia utilization in FY 2022.

Table 4 summarizes the payment comparison and estimated fiscal impact.

Table 4. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	137.5%
Colorado Repriced Amount	$36,268,689
Medicare Repriced Amount	$26,370,722
Est. FY 2022 Total Fund Impact	**$(9,897,967)**

Table 4 can be interpreted to mean that for Anesthesia services under review, Colorado Medicaid pays an estimated 137.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $(9,897,967). Detailed comparison results can be found in **Appendix B2**.

Ambulatory Surgical Centers (ASC) Payment Comparison

There is a matching Medicare rate for over 99.8% of the ASC utilization in FY 2022.

Table 5 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 5. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	53.5%
Colorado Repriced Amount	$10,832,192
Medicare Repriced Amount	$20,265,101
Est. FY 2022 Total Fund Impact	**$9,432,909**

Table 5 can be interpreted to mean that for ASC services under review, Colorado Medicaid pays an estimated 53.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $9,432,909. However, this comparison only uses the primary line of each encounter in an attempt to match Medicare repricing to the methodology that Colorado Medicaid uses to pay for ASC services. Detailed comparison results can be found in **Appendix B2**.

Fee-for-service Behavioral Health Services Payment Comparison

There is a matching Medicare rate for over 96.8% of the FFS Behavioral Health utilization in FY 2022.

Table 6 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 6. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	97.0%
Colorado Repriced Amount	$ 18,175,906
Medicare Repriced Amount	$ 18,732,206
Est. FY 2022 Total Fund Impact	**$ 556,300**

Table 6 can be interpreted to mean that for FFS Behavioral Health services under review, Colorado Medicaid pays an estimated 97.0% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $556,300. Detailed comparison results can be found in **Appendix B2**.

Maternity Services Payment Comparison

There is a matching Medicare rate for over 95.5% of the Maternity utilization in FY 2022.

Table 7 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 7. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	76.1%
Colorado Repriced Amount	$28,378,660
Medicare Repriced Amount	$37,313,704
Est. FY 2022 Total Fund Impact	**$8,935,044**

Table 7 can be interpreted to mean that for Maternity services under review, Colorado Medicaid pays an estimated 76.1% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $8,935,044. Detailed comparison results can be found in **Appendix B2**.

Abortion Services Payment Comparison

Due to having less than 30 claims, information cannot be shared due to HIPAA and PHI regulations.

Pediatric Behavioral Therapy Services Payment Comparison - Method 1: Including Nebraska

Table 8.1 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 8.1 Estimated Fiscal Impact

Colorado as a Percentage of Medicare	78.7%
Colorado Repriced Amount	$ 126,433,251
Other States Repriced Amount	$ 160,714,783
Est. FY 2022 Total Fund Impact	**$ 34,281,532**

Table 8.1 can be interpreted to mean that for Pediatric Behavioral Therapy services under review, Colorado Medicaid pays an estimated 78.7% of other ten states. Had Colorado Medicaid reimbursed at 100.00% of the other ten states rates in FY 2022, the estimated impact to the Total Fund would be $34,281,532. Detailed comparison results can be found in **Appendix B2**.

Pediatric Behavioral Therapy Services Payment Comparison - Method 2: Excluding Nebraska

Table 8.2 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 8.2 Estimated Fiscal Impact

Colorado as a Percentage of Medicare	90.7%
Colorado Repriced Amount	$ 126,433,251
Other States Repriced Amount	$ 139,447,581
Est. FY 2022 Total Fund Impact	**$ 13,019,386**

Table 8.2 can be interpreted to mean that for Pediatric Behavioral Therapy services under review, Colorado Medicaid pays an estimated 90.7% of other nine states. Had Colorado Medicaid reimbursed at 100.00% of the other nine states rates in FY 2022 except for 97158, the estimated impact to the Total Fund would be $13,019,386. Detailed comparison results can be found in **Appendix B2**.

Dental Services Payment Comparison

There is a matching ADA (American Dental Association) rate for over 32.4% of the dental services utilization in FY 2022.

Table 9 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 9. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	49.8%
Colorado Repriced Amount	$ 301,745,345
ADA Repriced Amount	$ 606,171,602
Est. FY 2022 Total Fund Impact	**$ 304,426,257**

Table 9 can be interpreted to mean that for dental services under review, Colorado Medicaid pays an estimated 49.8% of ADA. Had Colorado Medicaid reimbursed at 100.00% of the ADA rates in FY 2022, the estimated impact to the Total Fund would be $304,426,257. Detailed comparison results can be found in **Appendix B2**.

Digestive System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.9% of the Digestive System surgeries utilization in FY 2022.

Table 10 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 10. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	96.4%
Colorado Repriced Amount	$21,656,071
Medicare Repriced Amount	$22,469,116
Est. FY 2022 Total Fund Impact	**$813,045**

Table 10 can be interpreted to mean that for Digestive System surgeries under review, Colorado Medicaid pays an estimated 96.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $813,045. Detailed comparison results can be found in **Appendix B2**.

Musculoskeletal System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 99.5% of the Musculoskeletal System surgeries utilization in FY 2022.

Table 11 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 11. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	66.4%
Colorado Repriced Amount	$24,538,187
Medicare Repriced Amount	$36,927,306
Est. FY 2022 Total Fund Impact	**$12,389,119**

Table 11 can be interpreted to mean that for Musculoskeletal System surgeries under review, Colorado Medicaid pays an estimated 66.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $12,389,119. Detailed comparison results can be found in **Appendix B2**.

Cardiovascular System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.2% of the Cardiovascular System surgeries utilization in FY 2022.

Table 12 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 12. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	162.4%
Colorado Repriced Amount	$17,675,644
Medicare Repriced Amount	$10,881,937
Est. FY 2022 Total Fund Impact	**($6,793,706)**

Table 12 can be interpreted to mean that for Cardiovascular System surgeries under review, Colorado Medicaid pays an estimated 162.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be ($6,793,706). Detailed comparison results can be found in **Appendix B2**.

Respiratory System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 99.5% of the Respiratory System surgeries utilization in FY 2022.

Table 13 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 13. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	82.5%
Colorado Repriced Amount	$5,026,476
Medicare Repriced Amount	$6,092,153
Est. FY 2022 Total Fund Impact	**$1,065,677**

Table 13 can be interpreted to mean that for Respiratory System surgeries under review, Colorado Medicaid pays an estimated 82.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $1,065,677. Detailed comparison results can be found in **Appendix B2**.

Integumentary System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.2% of the Integumentary System surgeries utilization in FY 2022.

Table 14 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 14. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	63.5%
Colorado Repriced Amount	$10,310,353
Medicare Repriced Amount	$16,229,309
Est. FY 2022 Total Fund Impact	**$5,918,956**

Table 14 can be interpreted to mean that for Integumentary System surgeries under review, Colorado Medicaid pays an estimated 63.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $5,918,956. Detailed comparison results can be found in **Appendix B2**.

Eye & Auditory System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.4% of the Eye & Auditory surgeries utilization in FY 2022.

Table 15 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 15. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	95.0%
Colorado Repriced Amount	$8,529,687
Medicare Repriced Amount	$8,975,288
Est. FY 2022 Total Fund Impact	**$445,601**

Table 15 can be interpreted to mean that for Eye & Auditory surgeries under review, Colorado Medicaid pays an estimated 95.0% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $445,601. Detailed comparison results can be found in **Appendix B2**.

Other (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.9% of the Other surgeries utilization in FY 2022.

Table 16 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 16. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	78.2%
Colorado Repriced Amount	$21,227,515
Medicare Repriced Amount	$27,145,528
Est. FY 2022 Total Fund Impact	**$5,918,013**

Table 16 can be interpreted to mean that for Other surgeries under review, Colorado Medicaid pays an estimated 78.2% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $5,918,013. Detailed comparison results can be found in **Appendix B2**.

Co-Surgeries Payment Comparison

There is no co-surgery payment comparison data.

Appendix A – Cycle 1 Year 1 Methodologies and Data

Provides explanations of methodologies and data used in this report.

Executive Summary

The Colorado Department of Health Care Policy and Financing (HCPF) contracted with the actuarial firm **CBIZ Optumas (Optumas)** and worked collaboratively to compare Colorado Medicaid provider rates to Medicare or other comparable rates (e.g., other states' Medicaid rates).

The following services were reviewed by **Optumas** as part of the 2023 Medicaid Provider Rate Review Analysis Report:

- Anesthesia
- Ambulatory Surgical Centers (ASC)
- Fee-for-Service Behavioral Health Services (FFS BH)
- Maternity Services
- Abortion Services
- Pediatric Behavioral Therapy (PBT)
- Dental Services
- Surgeries:
    - Digestive System
    - Musculoskeletal System
    - Cardiovascular System
    - Respiratory System
    - Integumentary System
    - Eye & Auditory System
    - Other
    - Co-Surgery

The work performed on Cycle 1 Year 1 services was comprised of the following analyses:

1) Data validation
2) Rate crosswalk
3) Utilization adjusted rate comparison

The data validation process includes:

- Volume checks over time to determine completeness and reliability of data; and
- Determination of relevant utilization base and appropriate exclusions

The rate comparison benchmark analysis for July 1, 2021 – June 30, 2022 (FY 2022) compares Colorado Medicaid's latest fee schedule's estimated reimbursement with the estimated reimbursement of the overall benchmark(s). The rate comparison benchmark analysis considers Medicare rates as the comparator. In prior years, and the current year, when comparable Medicare rates were not available, an average rate from a selected group of other states was used.

All else being equal, if Colorado Medicaid were to reimburse at 100.00% of the overall benchmark, expenditures for FY 2022 would reflect the estimated total fund impact summarized in **Table 1**.

Table 1. Colorado as a Percent of the Medicare/Other States Benchmark and Estimated FY 2022 Fund Impact

Service Group	Colorado Repriced	Medicare Repriced	Colorado as a Percent of Medicare	Estimated FY 2022 Total Fund Impact
Anesthesia	$36,268,689	$26,370,722	137.5%	$(9,897,967)
Ambulatory Surgical Centers (ASC)*	$10,832,192	$20,265,101	53.5%	$9,432,909
Fee-for-Service Behavioral Health Services (FFS BH)	$18,175,906	$18,732,206	97.0%	$556,300
Maternity Services	$28,378,660	$37,313,704	76.1%	$8,935,044
Abortion Services	NA	NA	NA	NA
Pediatric Behavioral Therapy (PBT):				
Method 1: Including Nebraska	$126,433,251	$160,714,783	78.7%	$34,281,532
Method 2: Excluding Nebraska	$126,433,251	$139,447,581	90.7%	$13,019,386
Dental Services	$301,745,345	$606,171,602	49.8%	$304,426,257
Surgeries:				
Digestive System	$21,656,071	$22,469,116	96.4%	$813,045
Musculoskeletal System	$24,538,187	$36,927,306	66.4%	$12,389,119
Cardiovascular System**	$17,675,644	$10,881,937	162.4%	($6,793,706)
Respiratory System	$5,026,476	$6,092,153	82.5%	$1,065,677
Integumentary System	$10,310,353	$16,229,309	63.5%	$5,918,956
Eye & Auditory System	$8,529,687	$8,975,288	95.0%	$445,601
Other	$21,227,515	$27,145,528	78.2%	$5,918,013
Co-Surgery	NA	NA	NA	$1,759,670

The comparison for Ambulatory Surgical Centers uses the primary line of each encounter only. In general, Colorado Medicaid only reimburses for the most expensive ASC service on an encounter, but Medicare pays for additional ASC services, though sometimes at a reduced rate.

*****Here these repriced amounts, benchmark ratio and fund impact for cardiovascular surgery service is based on the repricing methodology which is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. In addition, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service.***

Data Validation

The Department initially provided three years (January 2019 – December 2021) of eligibility data and fee-for-service (FFS) claims data to **Optumas**. For the Rate Comparison analysis, the Department sought to use FY 2022 for the benchmark comparison, so an additional three months of data was provided (July 2022 – September 2022). The data validation process included utilization and dollar volume summaries over time which were validated against the expectations of the Department and Optumas based on prior analyses to identify potential inconsistencies. In addition, a frequency analysis was performed to examine valid values

appearing across all fields contained in the data. Overall, results of this process suggested that the FY 2022 data for each service was reliable.

Next, the data was reviewed to determine the relevant utilization after accounting for applicable exclusions. The exclusion criteria adhere to the general guidelines set forth in the Rate Review Schedule:[1]

- Claims attributed to members that are non-TXIX Medicaid eligible, i.e., Child Health Plan *Plus* (CHP+) program;
- Claims attributed to members with no corresponding eligibility span; and
- Claims associated with members enrolled in Medicaid and Medicare (dual membership).

Furthermore, for the rate comparison benchmark, the validation process included additional exclusions:

- Procedure codes that are on the Colorado fee schedule as “manually priced” or “not a benefit” or were not found on the schedule, which are reflected as “No Medicaid rate.”
- Procedure codes that do not have a comparable Medicare rate, which are reflected as “No Medicare rate.”
- If both prior cases are true, then the line is reflected as “No Medicare/Medicaid rate.”
- If there is no appropriate benchmark rate from other states or ADA fee schedule, the line is reflected as “No other state rate.”
- If a procedure code had no valid utilization during FY22, the line is reflected as “No valid utilization.”

The list of procedure codes that were excluded from this analysis are shown in **Table 2(a)** below.

Table 2(a). List of Procedure Codes Excluded
See the attached workbook with Table 2(a).

Except for Ambulatory Surgical Centers (ASC), which use groupers instead of procedure code for analysis, the number of excluded procedure codes for each service group is shown in **Table 2(b)** below.

[1] See the Rate Review Schedule on the Department’s Medicaid Provider Rate Review Advisory Committee (MPRRAC) website.

Table 2(b). Count of Procedure Codes Excluded

Service Group	No Medicaid Rate	No Medicare Rate	No Medicaid or Medicare Rate	No other state rate	No ADA rate or no Medicaid/ ADA rate	No valid utilization
Anesthesia	35	4	0	0	0	6
Maternity Services	0	2	0	0	0	6
Pediatric Behavioral Therapy (PBT) – same for two methods	0	0	0	1	0	0
Abortion	0	0	0	0	0	7
Dental	23	0	0	0	176	173
Surgery	4	42	56	0	0	1,663

Services were priced to the Colorado Medicaid fee schedules at the procedure code level. The summary of exclusions from the FY 2022 base data can be found in **Appendices B1(a) - B1(g)**.

FY 2022 claims data were selected as the base data of the repricing analysis because they yield an annualized result derived from the most recent experience. There is an inherent processing lag in claims between the time a claim is incurred and when it is billed, i.e., a concept referred to as claims runout. Claims rendered in any given month can take weeks or months to be reported in the claims system. The claims data for Cycle 1 Year 1 services were provided with three months of claims runout. The raw claims data reflects the vast majority of FFS experience for Cycle 1 Year 1 services in FY 2022 and an IBNR (Incurred but not reported) analysis was not performed.

After the data validation step, the rate comparison benchmark analysis was performed.

Rate Comparison Benchmark Analysis

The first step in the rate comparison benchmark analysis was a repricing exercise using the most recent Colorado Medicaid fee schedule with rates effective July 1, 2022. However, a new repricing based on the July 1, 2023, Colorado Medicaid fee schedule was implemented in July 2023.

Anesthesia rates were reviewed by procedure code to obtain a Colorado repriced amount. No modifiers were considered when pulling rates from the Medicare physician fee schedule because modifiers are not considered when repricing Anesthesia using the Colorado Medicaid physician fee schedule. The Medicare fee schedule was then used to identify comparable rates, reference publicly available documentation on reimbursement policy, and analyze relevant fee schedules specific to Colorado to produce a more valid comparison.[2]

ASC procedure codes were first grouped into ASC groups A01 through A11. The intensity of service goes up from A01 and the rate for each group also increases. The rates range from

[2] The payment rate comparison is influenced by the choice of fee schedule since Colorado-specific Medicare rates are higher than those derived from unadjusted national relative value units. All Medicare rates and relevant information were effective calendar year 2023.

$280.02 for A01 to $3,574.20 for A11. Colorado Medicaid, in general, covers payment for the highest intensity service on any given encounter, which is different from the methodology that Medicare uses to pay ASC claims. For Medicare claims, the highest intensity service is covered according to the fee schedule, and subsequent lines with ASC services are paid, potentially, at a discounted rate. For this reason, the results of the rate comparison for ASC are reflective of only the primary line on any encounter being repriced for both Medicaid and Medicare. Because Colorado Medicaid does not have different rates for ASC based on modifiers, only the procedure codes were used and cross walked to ASC groups.

FFS BH procedure codes were grouped into two groups: therapy codes (13 codes) and assessment codes (18 codes). All FFS BH rates were reviewed by procedure code and repriced using the Colorado Medicaid physician fee schedule. Here the rate for a FFS BH procedure code without modifier on the Colorado Medicaid physician fee schedule was selected as the CO Medicaid rate, excluding the same procedure code with a specified modifier. 30 procedure codes were compared with Medicare rates and one code was compared with the average rate of other nine states (Florida, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington). For Medicare rates, non-facility fees were selected as default.

Maternity rates were reviewed by procedure code to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid physician fee schedule unless there was a note on the fee schedule to “See Prenatal Plus Fee Schedule.” However, the procedure codes for rates on the Prenatal Plus schedule are not rates covered by Medicare, so those were excluded from the rate comparison. For Medicare rates, different fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data.

Although a Medicare rate is available to be used as the benchmark rate for two abortion procedure codes, this review used the average rates from three (California, Oregon and Illinois) or two other states (California and Illinois) as the benchmark rate because the Medicare base rate was too low.

PBT rates were reviewed by procedure code and to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid physician fee schedule. However, a transformation was conducted to the procedure code 97151 (without modifier) as it was a flat rate, while other states use a 15-minutes unit base. The rate was then divided by 32 since it was designed originally based on an 8-hour service assumption. There are two methods for the PBT analysis. The first method is with ten states including Nebraska. Ten states (Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington) were selected as the comparison states based on recommendations from internal subject matter experts and external providers. In addition, both Colorado Medicaid rates and ten states’ PBT rates were adjusted based on the current Cost of Living Index, which was sourced from C2ER (Council for Community & Economic Research), with 2023 Q1 as the time period). Finally, the adjusted repriced Colorado Medicaid PBT rates were compared with the adjusted averaged rates from ten states. The second method is with nine states excluding Nebraska. HCPF recommended removing Nebraska out of the benchmark state list since its PBT rates were an extreme outlier compared to the other 9 states. The final states used in the second method are: Florida, Massachusetts, Maryland,

North Carolina, Nevada, Oregon, Texas, Utah, and Washington. The remaining steps followed those used in the first method.

Dental rates were reviewed by procedure code to obtain a Colorado repriced amount. Rates were taken from the Colorado Medicaid dental fee schedule. American Dental Association (ADA) survey 2022 data was used as the benchmark rate. 151 out of 523 Colorado Medicaid dental procedure codes were compared with ADA survey rates.

All surgery rates were reviewed by procedure code and repriced using the Colorado physician fee schedule, similar to repricing for Maternity. For all surgeries, Medicare's base rate, which is listed by procedure code, includes a breakout for facility versus non-facility and is considered to compare an appropriate rate. In addition, there was a supplemental analysis for cardiovascular surgeries, by using Medicare's non-facility fees as the comparison base.

In previous cycles when a comparable Medicare rate could not be found, an average of other states' rates was used. This left some data for which a comparable rate could not be found under the Cycle 1 Year 1 service categories. The utilization in the base data associated with these non-comparable claims were excluded for the remainder of the rate comparison benchmark analysis.

The final step consisted of applying the base utilization to Colorado Medicaid's latest available fee schedule, as well as the matched rates from Medicare. This entailed multiplication of utilization and the corresponding rates from each source, followed by subtraction of third-party liability (TPL) and copayments, to calculate the estimated total dollars that would theoretically be reimbursed by each source.

The range of ratios derived from comparing Health First Colorado rates to those of Medicare is shown by the service group in **Table 3**.

Table 3. Rate Ratio Ranges

Service Group	Medicare/Other States
Anesthesia	129% - 271.7%
Ambulatory Surgical Centers (ASC)*	26.2% - 79.5%
FFS BH	51.1% - 401.3%
Maternity Services	54.8% - 124.3%
Abortion	23.0% - 57.7%
PBT - Method 1: Including Nebraska	36.0% - 84.8%
PBT - Method 2: Excluding Nebraska	41.9% - 128.5%
Dental	10.8% - 135.9%
Surgery - Digestive System	6.0% - 1453.2%
Surgery - Musculoskeletal System	6.2% - 1734.1%
Surgery - Cardiovascular System	5.6% - 1302.4%
Surgery - Respiratory System	6.4% - 823.3%
Surgery - Integumentary System	4.7% - 470.9%
Surgery - Eye & Auditory System	7.8% - 653.8%
Surgery - Other	2.5% - 1335.2%

As an example, the top figure in **Table 3** can be interpreted to mean that when comparing Anesthesia Services to Medicare rates by procedure code, the Colorado Medicaid rates were anywhere from 129% to 271.7% of the Medicare rate.

Estimated expenditures were only compared for the subset of Cycle 1 Year 1 services that are common between Colorado Medicaid and Medicare except for PBT, abortion, and dental services. In other words, if no comparable rate could be found for a specific service offered in Colorado Medicaid, then the associated utilization and costs were not shown within the comparison results.

In the service-specific payment comparison sections of the narrative that follow, more detailed information can be found on the Medicare portions of the rate comparison benchmark.

Anesthesia Payment Comparison

There is a matching Medicare rate for over 99.2% of the Anesthesia utilization in FY 2022.

Table 4 summarizes the payment comparison and estimated fiscal impact.

Table 4. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	137.5%
Colorado Repriced Amount	$36,268,689
Medicare Repriced Amount	$26,370,722
Est. FY 2022 Total Fund Impact	**$(9,897,967)**

Table 4 can be interpreted to mean that for Anesthesia services under review, Colorado Medicaid pays an estimated 137.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $(9,897,967). Detailed comparison results can be found in **Appendix B2**.

Ambulatory Surgical Centers (ASC) Payment Comparison

There is a matching Medicare rate for over 99.8% of the ASC utilization in FY 2022.

Table 5 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 5. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	53.5%
Colorado Repriced Amount	$10,832,192
Medicare Repriced Amount	$20,265,101
Est. FY 2022 Total Fund Impact	**$9,432,909**

Table 5 can be interpreted to mean that for ASC services under review, Colorado Medicaid pays an estimated 53.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $9,432,909. However, this comparison only uses the primary line of each encounter in an attempt to match Medicare repricing to the methodology that Colorado Medicaid uses to pay for ASC services. Detailed comparison results can be found in **Appendix B2**.

Fee-for-service Behavioral Health Services Payment Comparison

There is a matching Medicare rate for over 96.8% of the FFS Behavioral Health utilization in FY 2022.

Table 6 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 6. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	97.0%
Colorado Repriced Amount	$ 18,175,906
Medicare Repriced Amount	$ 18,732,206
Est. FY 2022 Total Fund Impact	**$ 556,300**

Table 6 can be interpreted to mean that for FFS Behavioral Health services under review, Colorado Medicaid pays an estimated 97.0% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $556,300. Detailed comparison results can be found in **Appendix B2**.

Maternity Services Payment Comparison

There is a matching Medicare rate for over 95.5% of the Maternity utilization in FY 2022.

Table 7 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 7. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	76.1%
Colorado Repriced Amount	$28,378,660
Medicare Repriced Amount	$37,313,704
Est. FY 2022 Total Fund Impact	**$8,935,044**

Table 7 can be interpreted to mean that for Maternity services under review, Colorado Medicaid pays an estimated 76.1% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $8,935,044. Detailed comparison results can be found in **Appendix B2**.

Abortion Services Payment Comparison

Due to having less than 30 claims, information cannot be shared due to HIPAA and PHI regulations.

Pediatric Behavioral Therapy Services Payment Comparison - Method 1: Including Nebraska

Table 8.1 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 8.1 Estimated Fiscal Impact

Colorado as a Percentage of Medicare	78.7%
Colorado Repriced Amount	$ 126,433,251
Other States Repriced Amount	$ 160,714,783
Est. FY 2022 Total Fund Impact	**$ 34,281,532**

Table 8.1 can be interpreted to mean that for Pediatric Behavioral Therapy services under review, Colorado Medicaid pays an estimated 78.7% of other ten states. Had Colorado Medicaid reimbursed at 100.00% of the other ten states rates in FY 2022, the estimated impact to the Total Fund would be $34,281,532. Detailed comparison results can be found in **Appendix B2**.

Pediatric Behavioral Therapy Services Payment Comparison - Method 2: Excluding Nebraska

Table 8.2 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 8.2 Estimated Fiscal Impact

Colorado as a Percentage of Medicare	90.7%
Colorado Repriced Amount	$ 126,433,251
Other States Repriced Amount	$ 139,447,581
Est. FY 2022 Total Fund Impact	**$ 13,019,386**

Table 8.2 can be interpreted to mean that for Pediatric Behavioral Therapy services under review, Colorado Medicaid pays an estimated 90.7% of other nine states. Had Colorado Medicaid reimbursed at 100.00% of the other nine states rates in FY 2022 except for 97158, the estimated impact to the Total Fund would be $13,019,386. Detailed comparison results can be found in **Appendix B2**.

Dental Services Payment Comparison

There is a matching ADA (American Dental Association) rate for over 32.4% of the dental services utilization in FY 2022.

Table 9 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 9. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	49.8%
Colorado Repriced Amount	$ 301,745,345
ADA Repriced Amount	$ 606,171,602
Est. FY 2022 Total Fund Impact	**$ 304,426,257**

Table 9 can be interpreted to mean that for dental services under review, Colorado Medicaid pays an estimated 49.8% of ADA. Had Colorado Medicaid reimbursed at 100.00% of the ADA rates in FY 2022, the estimated impact to the Total Fund would be $304,426,257. Detailed comparison results can be found in **Appendix B2**.

Digestive System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.9% of the Digestive System surgeries utilization in FY 2022.

Table 10 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 10. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	96.4%
Colorado Repriced Amount	$21,656,071
Medicare Repriced Amount	$22,469,116
Est. FY 2022 Total Fund Impact	**$813,045**

Table 10 can be interpreted to mean that for Digestive System surgeries under review, Colorado Medicaid pays an estimated 96.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $813,045. Detailed comparison results can be found in **Appendix B2**.

Musculoskeletal System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 99.5% of the Musculoskeletal System surgeries utilization in FY 2022.

Table 11 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 11. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	66.4%
Colorado Repriced Amount	$24,538,187
Medicare Repriced Amount	$36,927,306
Est. FY 2022 Total Fund Impact	**$12,389,119**

Table 11 can be interpreted to mean that for Musculoskeletal System surgeries under review, Colorado Medicaid pays an estimated 66.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $12,389,119. Detailed comparison results can be found in **Appendix B2**.

Cardiovascular System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.2% of the Cardiovascular System surgeries utilization in FY 2022.

Table 12 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 12. Estimated Fiscal Impact	
Colorado as a Percentage of Medicare	162.4%
Colorado Repriced Amount	$17,675,644
Medicare Repriced Amount	$10,881,937
Est. FY 2022 Total Fund Impact	**($6,793,706)**

Table 12 can be interpreted to mean that for Cardiovascular System surgeries under review, Colorado Medicaid pays an estimated 162.4% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be ($6,793,706). Detailed comparison results can be found in **Appendix B2**.

Respiratory System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 99.5% of the Respiratory System surgeries utilization in FY 2022.

Table 13 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 13. Estimated Fiscal Impact	
Colorado as a Percentage of Medicare	82.5%
Colorado Repriced Amount	$5,026,476
Medicare Repriced Amount	$6,092,153
Est. FY 2022 Total Fund Impact	**$1,065,677**

Table 13 can be interpreted to mean that for Respiratory System surgeries under review, Colorado Medicaid pays an estimated 82.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $1,065,677. Detailed comparison results can be found in **Appendix B2**.

Integumentary System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.2% of the Integumentary System surgeries utilization in FY 2022.

Table 14 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 14. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	63.5%
Colorado Repriced Amount	$10,310,353
Medicare Repriced Amount	$16,229,309
Est. FY 2022 Total Fund Impact	**$5,918,956**

Table 14 can be interpreted to mean that for Integumentary System surgeries under review, Colorado Medicaid pays an estimated 63.5% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $5,918,956. Detailed comparison results can be found in **Appendix B2**.

Eye & Auditory System (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.4% of the Eye & Auditory surgeries utilization in FY 2022.

Table 15 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 15. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	95.0%
Colorado Repriced Amount	$8,529,687
Medicare Repriced Amount	$8,975,288
Est. FY 2022 Total Fund Impact	**$445,601**

Table 15 can be interpreted to mean that for Eye & Auditory surgeries under review, Colorado Medicaid pays an estimated 95.0% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $445,601. Detailed comparison results can be found in **Appendix B2**.

Other (Surgeries) Payment Comparison

There is a matching Medicare rate for over 98.9% of the Other surgeries utilization in FY 2022.

Table 16 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 16. Estimated Fiscal Impact

Colorado as a Percentage of Medicare	78.2%
Colorado Repriced Amount	$21,227,515
Medicare Repriced Amount	$27,145,528
Est. FY 2022 Total Fund Impact	**$5,918,013**

Table 16 can be interpreted to mean that for Other surgeries under review, Colorado Medicaid pays an estimated 78.2% of Medicare. Had Colorado Medicaid reimbursed at 100.00% of the Medicare rates in FY 2022, the estimated impact to the Total Fund would be $5,918,013. Detailed comparison results can be found in **Appendix B2**.

Co-Surgeries Payment Comparison

There is no co-surgery payment comparison data.

COLORADO
Department of Health Care Policy & Financing

Appendix B1 - Base Data Summary

The following appendices provide more detailed rate comparison benchmark summaries and results that were introduced and discussed in the narrative.

Table B1(a): Anesthesia

	Anesthesia
Data Received from HCPF	$ 45,982,369
Non-Anesthesia Codes Excluded	$ 9,532,977
Anesthesia Data Used for Analysis	$ 36,449,392
Exclusions	
Dual Eligible	$ 178,899
No Eligibility Span	$ 13,478
Child Health Plan Plus (CHP+)	$ 959
Non-TXIX	$ 1,192,845
No Comparison Available	$ 361,222
Total Exclusions	$ 1,747,403
Base Medicaid Data	$ 34,701,989
Percentage of Raw	95.2%

Note: as an example, the Anesthesia final figures in the above table can be interpreted to mean that 95.2% (accounting for $34,701,989 in unadjusted paid dollars) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Table B1(b): Ambulatory Surgical Centers (ASC)

	ASC
Data Received from HCPF	$ 26,710,587
Non-ASC Codes Excluded	$ 13,267,882
ASC Data Used for Analysis	13,442,706
Exclusions	
Dual Eligible	56,550
No Eligibility Span	917
Child Health Plan Plus (CHP+)	-
Non-TXIX	1,876
No ASC Group	2,252
No Comparison Available	$ 2,865,754
Total Exclusions	$ 2,927,348
Base Medicaid Data	$ 10,515,358
Percentage of Raw	78.2%

The percentage of raw dollars for ASC is lower than other services because of the comparison methodology used. Colorado Medicaid, in general, only reimburses for the most expensive ASC service on an encounter, but Medicare pays for additional ASC services, though sometimes at a reduced rate. To ensure that an apples-to-apples comparison was done, only the primary line was repriced using the Colorado fee schedule and the Medicare fee schedule. This resulted in an overall greater reduction in the base data that was repriced.

Table B1(c): Fee-for-Service Behavioral Health Services

	Fee-for-Service Behavioral Health
Base data	$ 18,790,895
Eligibility Exclusions	
Dual Eligible	$ 45,456
No eligibility Span	$ 5,047
Child Health Plan Plus (CHP+)	$ -
Non-TXIX	$ 5,656
Total Exclusions	$ 56,159
Base Medicaid Data	$ 18,734,736
Percentage of Raw	99.7%

Note: as an example, the FFS behavioral health final figures in the above table can be interpreted to mean that 99.7% (accounting for $18,734,736 in unadjusted paid dollars) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Table B1(d): Maternity Services

	Maternity
Base Data	$ 28,610,463
Eligibility Exclusions	
Dual Eligible	$ 10,044
No Eligibility Span	$ 4,226
Child Health Plan Plus (CHP+)	$ 1,632
Non-TXIX	$ 2,423,084
Pre-Natal Plus Program	$ 433,994
No Medicare Rate Found	$ 550,397
Total Exclusions	$ 3,423,377
Base Medicaid Data	$ 25,187,086
Percentage of Raw	88.0%

Note: as an example, the maternity final figures in the above table can be interpreted to mean that88% (accounting for $25,187,086 in unadjusted paid dollars) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Table B1(e): Pediatric Behavioral Therapy

	Pediatric Behavioral Therapy
Base data	$ 120,772,992
Eligibility Exclusions	
Dual Eligible	$ 121,824
No eligibility Span	$ 47,082
Child Health Plan Plus (CHP+)	$ -
Non-TXIX	$ -
Total Exclusions	$ 168,906
Base Medicaid Data	$ 120,604,087
Percentage of Raw	99.9%

Note: as an example, the pediatric behavioral therapy final figures in the above table can be interpreted to mean that 99.9% (accounting for $120,604,087 in unadjusted paid dollars) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Table B1(f): Dental

	Dental
Base data	$ 298,869,522
Eligibility Exclusions	
Dual Eligible	$ 22,661,304
No Eligibility Span	$ 68,373
Child Health Plan Plus (CHP+	
Non-TXIX	$ 77,673
Total Exclusions	$ 22,807,350
Base Medicaid Data	$ 276,062,172
Percentage of Raw	92.4%

Note: as an example, the dental final figures in the above table can be interpreted to mean that 92.4% (accounting for $276,062,172 in unadjusted paid dollars including unreviewed codes due to no matched ADA rates or discontinued use in 2023) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Table B1(g): Surgery

	Surgery
Base data	$ 107,230,075
Eligibility Exclusions	
Dual Eligible	$ 866,612
No Eligibility Span	$ 40,569
Child Health Plan Plus (CHP+)	$ 1,961
Non-TXIX	$ 1,545,698
Total Exclusions	$ 2,454,839
Base Medicaid Data	$ 104,775,236
Percentage of Raw	97.7%

Note: as an example, the surgery final figures in the above table can be interpreted to mean that 97.7% (accounting for $104,775,236 in unadjusted paid dollars) of the FY 2022 data provided by the Department was appropriate for use in the payment rate comparison analysis.

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Appendix B2 - Rate Ratios Results

Rate ratios are shown for all unique combinations of Colorado Medicaid and Medicare or other states' rates comparison rates found in the rate comparison benchmark analysis by service.

See the attached workbook with Tables B2(a) through B2(h).

B2(a) – Anesthesia

B2(b) - Ambulatory Surgical Centers (ASC)

B2(c) – FFS Behavioral Health Services

B2(d) – Maternity

B2(e) - Abortion

B2(f) - Pediatric Behavioral Therapy

B2(g) – Dental

B2(h) - Surgery

Appendix C - Fiscal Impact (MPRRAC)

Category of Service	Rate Benchmark Ratio	Total Fiscal Impact	General Fund
Anesthesia	137.50%	($9,897,967)	($2,896,344)
ASC	53.50%	$5,379,889	$1,574,264
FFS BH	97.00%	$319,452	$159,7268
PBT (including Nebraska)	78.70%	$34,281,532	$17,140,766
Maternity	76.10%	$8,942,246	$4,471,123
Abortion	NA	NA	
Dental	49.80%	$104,138,137	$19,015,624
Surgeries - Digestive	96.40%	($1,447,136)	($423,461)
Surgeries - Musculoskeletal	66.40%	$5,003,658	$1,464,171
Surgeries - Cardiovascular	162.40%	($7,723,131)	($2,259,943)
Surgeries - Respiratory	82.50%	$180,879	$52,929
Surgeries - Integumentary	63.50%	$3,216,801	$941,300
Surgeries - Eye and Auditory	95.00%	($176,581)	($51,671)
Surgeries - Other	78.20%	$1,809,649	$529,540
Co-Surgery	no analysis/no data	NA	NA
Total		**$144,027,428**	**$39,718,024**

Appendix C - Fiscal Impact (HCPF)

Category of Service	Rate Benchmark Ratio	Total Fiscal Impact	General Fund
Anesthesia	137.50%	($9,897,967)	($2,896,344)
ASC	53.50%	$4,366,634	$1,277,764
FFS BH	97.00%	$1,644,157	$822,078
PBT (excluding Nebraska)	90.70%	$13,019,386	$6,509,693
Maternity	76.10%	$8,494,404	$4,247,202
Abortion	NA	$325	$162
Dental	49.80%	$85,620,023	$15,634,217
Surgeries - Digestive	96.40%	($1,165,252)	($340,976)
Surgeries - Musculoskeletal	66.40%	$3,732,671	$1,092,254
Surgeries - Cardiovascular	74.80%	$2,842,496	$831,772
Surgeries - Respiratory	82.50%	($223,909)	($65,520)
Surgeries - Integumentary	63.50%	$2,081,628	$609,126
Surgeries - Eye and Auditory	95.00%	($383,945)	($112,350)
Surgeries - Other	78.20%	$505,358	$147,878
Co-Surgery	no analysis/no data	$1,759,670	$514,915
Total		**$112,395,679**	**$28,271,871**

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Appendix D - Stakeholder Feedback

Appendix D - Stakeholder Feedback 1
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Ambulatory Surgical Centers (ASCs) 2
Fee-for-service (FFS) Behavioral Health Services 3
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Musculoskeletal System Surgeries 63
Cardiovascular System Surgeries 64
Respiratory System Surgeries 72
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Appendix D contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings. Email feedback below is verbatim and unaltered from public stakeholders and did not undergo editing or factual verification by HCPF. All verbal feedback has been summarized to the best of HCPF's ability. The feedback below does not reflect HCPF's views and opinions on the rates of the Cycle 1 Services under review.

The feedback in this appendix was collected from March 01, 2023 through October 17, 2023.

All meeting recordings and meeting minutes can be found on HCPF's Rate Review website.

Anesthesia

Kris Smith
CarePoint Anesthesia Group

Question regarding dental anesthesia – Moderate anesthesia has been reimbursed at the same rate as general anesthesia despite all the additional training, equipment that the state requires to be safe and medications/products used for general anesthesia used in dental. Why have those have remained the same and is the committee going to be looking at that?

Ambulatory Surgical Centers (ASCs)

Christopher D, Skagen, JD
CASCA

*This is a written comment and no time to speak at the hearing is requested. CASCA thanks the Department for its attention to the ASC payment methodology. We are in support of having the payments align with Medicare, and we believe a benchmark of 80% is reasonable. CASCA would appreciate in the future having separate implant payments addressed, which create a problem with bundling of payments and creating a situation where an ASC is not able to do a procedure because they lose money based upon the cost of the implants that are more than the reimbursement rate. Again, we thank the Department for their work on this topic and are always available as a resource to help the Department with questions as they relate to the Ambulatory Surgery Center industry.

Ross Chod MD

I am hoping someone on the team can provide a response to issues below.
FROM WHAT I CAN SEE:
67039, 67040, 67108 are grouper 7: ASC makes $861.
67041, 67042, 67043 are grouper 5: ASC makes $621.
These procedures could very easily be done in ASC but never will be at these rates.
Medicare reimburses ASCs about $1900 for these procedures.
How much is medicaid spending to reimburse hospitals for these codes when done in the outpatient hospital setting? Outpatient hospital is the only place these surgeries can be done right now given the shortcoming of your ASC reimbursement schedule. Patients suffer when having to be operated on at a hospital instead of an ASC.

Also, From my search 67113 isn't included in a grouper at all.

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Fee-for-service (FFS) Behavioral Health Services

Alexandra Tomei

Speaking to the determination regarding the number of providers - there is data that at least 33% of ABA providers in Colorado with an NPI that identifies them with a behavior analyst taxonomy do not hold valid BACB or QABA credentials that would make them a behavior analyst. This is concerning when calculating provider adequacy in the state. In addition, when considering rates, there are multiple companies that have closed operations in Colorado but kept operations open in other states. Many of these companies cite the cost of providing services in the state as a major factor in being able to sustain business in the state. We are losing providers due to rates that are not comparable with surrounding states, and while other states' Medicaid programs are seeing 10-20% or higher increases in reimbursement, we still face less than adequate rate increases. Since 2019, ABA received an average of 4.3% in rate increases, when business operating costs have increased 43% on average in the same amount of time. What states were used to engage in this price comparison?

Jennifer Ryan and Lila Kimmel

Neuropsychological testing (codes 96136, 96137, 96132, 96133, within 90791) is included in Behavioral Health Services. This testing rate is not high enough to cover the cost of services. There are a handful of psychologists who are able to perform care, and Current Medicaid rate pays 50% less than private pay or other insurance. Psychotherapy rates (codes 90837 and 90838) are also not high enough to cover costs. There also needs to be an equity qualifier; Spanish speakers were identified as a specific population.

Guofeng Shen
Seven Dimension Behavioral Health

Medicaid Provider Reimbursement Rate for behavioral health service is low and cannot cover the operating cost.

Jennifer Paz Ryan
Elevated Insights Assessment

Would like to discuss the need to increase the rates for psychological and neuropsychological testing AND for adding a modifier that allows for multilingual clinicians to charge $75 per 60-minute unit for equity.

Travis Blevins
Behavior Services of the Rockies

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This is reason for the lack of providers in rural areas, and the lack of providers serving adults, and the lack of providers serving severe bx clients are the rates. The money, high salaries, and massive capital are in the clinic, with kiddos that are not aggressive, or terribly difficult. And Private Equity block schedule kids and parents drive their kids into therapy. The kids with severe issues, and might live outside the 15 mile radius don't get help. Community based services seeing clients in their home should be reimbursed at a higher rate than in clinic services. Rural areas should be reimbursed at a higher rate depending on the number of providers in the area. Or reimburse for drive time. The idea that the rate is same for a parent driving to a clinic to drop their child off, and a therapist driving to the home of a family is absurd The idea that services in Sterling CO or Lamar CO where there isn't a BCBA within 75 miles is reimbursed at the same rate as child brought to a clinic in Denver is ABSURD. The caps on adult services is ridiculous. Bands of allowable service dosage with varying amount of hours available for bx services SHOULD BE TIED TO THE TIER not the same for a tier 1 and a tier 7 on the SIS. Why are their no bx services for the EBD waiver? Why does EPSDT continue to deny medically necessary services based on location? Why does Acentra Health (previously known as KEPPRO) continue to deny authorizations by reviewers operating outside their scope of services with little knowledge of the field of practice? Why is the Federal Mental Health Parity Act (MHPAEA) ignored by the enforcing agent the Department of Insurance in Colorado? What is HCPF's plan to expand services and provide adequate coverage for ABA services in rural areas of Colorado? Why did the vast majority of School districts in Colorado fail to comply with developing a policy to address BILL HB20-1058 Behavior Analysts In Public Schools? What is the consequence of this noncompliance? We have been asking these questions without an answer. Can you provide us answers?

Lila Kimel
Kimel Psychological Services

I am hoping that we can increase the pay rate for psychological and neuropsychological evaluations in Colorado in order to keep up with what the state rate is with other insurances, and privately. I serve Spanish speakers, and I don't get compensated for my translation services. We also provide psychotherapy for individuals with autism, spectrum disorders, and other developmental disabilities. There is a risk that this will go to RAEs soon. As it is, we barely make ends meet to pay our staff salaries that will keep them with our practice. Please consider my plea for an increase from 100% that was just approved.

Jennifer Paz Ryan, M.Ed, Psy.D. (she/her/hers/ella)
Bilingual Co-Founder of Elevated Insights Assessment, LLC
www.elevatedinsights.org

I am writing as a representative of testing psychologists who specialize in neuropsych testing for developmental disabilities (ASD, DD, ID) for Medicaid which is currently a FFS. We were very excited at the July 14th meeting as MPRAC seemed to hear our plea for increasing specialty testing rates between 100-130% depending on the niche. Imagine our surprise when

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on Monday, July 17th, we learned that our testing codes were actually REDUCED without any notice. We found out when trying to run payroll and came up short!This is absolutely ridiculous and not mentioned in the call we had on Friday. Medicaid rates specifically related to psychological/neuropsychological testing were significantly reduced as of July 1, 2023. We NEVER received any notification and only realized it when we went to pay our providers and were negative. Here is a table of the rate changes:

Previous New Change
90791 $156.98 $161.69 + 2.9%
96136 $ 64.82 $ 43.82 - 32.4%
96137 $ 47.44 $ 40.49 - 14.6%
96132 $126.03 $105.50 -16.3%
96133 $ 99.82 $ 80.45 -19.4%

Please note that the only rate that increased is a code that can be used by ANY individual and does NOT require niche or specialty training. This means that HCPF and Medicaid are valuing the generalist while devaluing the specialist. As of today, July 24th there are approximately 8 practices (out of about 30) that do this type of testing that have made it clear that they will NOT be accepting Medicaid clients for testing due to these lowered rates. Three of these practices have Spanish speaking and bilingual licensed clinical psychologists. Only 5% of psychologists in the US even identify as Latinx/Hispanic and Spanish speaking. Even fewer are going to have the expertise for psych assessment. There is NO way we can pay our licensed psychologists that specialize in neuropsychological assessment salaries and benefits with these paltry rates. CHCO and community mental health services have made it clear that they alone CANNOT keep up with the need for testing and rely on us to provide these services. There is a current autism crisis in Colorado and this is going to be catastrophic.

David Briedis
Chief Growth Officer | Behavioral Innovations
www.StartABA.com |

Good afternoon. Thank you for your engagement with ABA providers during the December call hosted by Gina Robinson, and once again during the 3/24 MPRRAC meeting. In advance of the upcoming meeting this Friday 4/21, I wanted to share a summary analysis (attached for ease of reference). As a quick introduction, our company (Behavioral Innovations) is one of the largest ABA providers nationally with 71 total locations across TX, OK, and CO. In Colorado, we currently operate 8 locations which makes us one of the largest ABA providers in this specific community as well. We have invested meaningfully in training, mentorship, and compliance programs that some of our other payers have reviewed and recognized as best-in-class. As you’ve rightly recognized, the ABA provider community is on the brink of crisis. For transparency, our own centers are not profitable in Colorado. Because of the rate stagnation and wage pressures we face in Colorado, we have not opened a new location in the area in 2 years and instead have invested/expanded access to care elsewhere where it is more financially sustainable. In order to align on what is fair, equitable, and sustainable for HCPF and providers alike, we’ve tried to tackle the issue through several lenses:

Comparable Government Payors: Firstly, we believe it is appropriate to compare Colorado Medicaid rates with those of proximate Southwestern states. For our analysis, we've sampled Medicaid payers in Arizona, New Mexico and Oklahoma. On average, these states reimburse at a $16.00/hour premium, relative to Colorado, for the direct 1:1 therapy (CPT 97153) that represents 80-90% of total billable hours for most ABA providers. With ongoing inflation, we anticipate this will represent an ~35% premium over the current Colorado Medicaid rates by the time that any rate relief is potentially enacted effective 7/1/24.

Similarly, we believe Tricare reimbursement for providers in Colorado is a relevant and publicly available comparison (fee schedule found here). Tricare reimburses at a $16.72/hour premium, relative to Colorado Medicaid, for direct 1:1 therapy. With ongoing inflation, we anticipate this will represent an ~36% premium over the current Colorado Medicaid rates by the time that any rate relief is potentially enacted effective 7/1/24.

Break-even Analysis: Alternatively, we thought it might be helpful to see a representative P&L for a provider to help answer the question "where does the money all go?". In this exhibit, we've adjusted our own budget for the current year to demonstrate the costs incurred per hour of therapy. We similarly rolled this forward to 2024 to account for ongoing inflation and the extended timeline between now and any potential change to Colorado Medicaid rates 7/1/24. Please note that for simplicity, I've disregarded reimbursement and cost of the masters-level BCBA clinicians that supervise care. BCBAs roughly break-even (at best) for the assessment, supervision, and parent training services they provide and are reimbursed for and are not a source of profit for ABA providers. Our aim in this exhibit is to illustrate for you that for each $55.88 received as reimbursement for direct therapy provided to Colorado Medicaid members, we incur $71.08 of cost to provide services. This obviously is not sustainable. With ongoing inflation, we anticipate an ~34% increase over the current Colorado Medicaid rates will be required (effective 7/1/24) for providers to break-even and for HCPF to maintain adequate network coverage.

Proposal: Regardless of approach, an ~35% reimbursement rate increase appears to be equitable and in-line with market comparables we expect from government payors as of 7/1/24. While we've focused our review on 1:1 direct therapy (97153) for simplicity, we would propose a 35% increase across all CPT codes 97151-97158 pertaining to ABA therapy, effective 7/1/24. We acknowledge this is a material increase, but it is what is required for us (and other providers) to sustainably provide these critically needed services to children with autism in Colorado. If you are interested in discussing any of the above, I am available at your convenience.

Reference – comparable Medicaid fee schedules: Arizona, New Mexico, Oklahoma

Southwest Medicaid Reimbursement Rate Comparison			
	97153 Status Quo	2024 5% Inflation	2024 vs. CO
Medicaid Direct Therapy Reimbursement per Hour			
Arizona	$81.48	$85.55	*53%*
New Mexico	$64.76	$68.00	*22%*
Oklahoma	$69.40	$72.87	*30%*
Average	**$71.88**	**$75.47**	***35%***
Colorado Tricare	$72.60	**$76.23**	***36%***
Colorado Medicaid	$55.88		

Breakeven Analysis - Representative ABA Therapy Provider			
	2023 Status Quo	2024 5% Inflation	Breakeven
Direct Therapy Reimbursement per Hour (97153)	**$55.88**	**$55.88**	**$74.64**
RBT/Therapist Wages - Billable Time	$19.93	$20.92	$20.92
RBT/Therapist Wages - Training/Admin/Other	$6.41	$6.73	$6.73
Center Admin/Ops Manager Wages	$4.13	$4.34	$4.34
Insurance/Payroll Taxes/Other Direct Costs	$8.42	$8.84	$8.84
Gross Profit	$16.99	$15.04	$33.80
Gross Margin %	*30%*	*27%*	*45%*
Rent/Utilities/Other Indirect Costs	$11.65	$12.24	$12.24
Home Office Support	$8.99	$9.44	$9.44
Other (Income) / Expenses	$7.70	$8.08	$8.08
Depreciation & Amortization	$3.84	$4.04	$4.04
Net Income	($15.20)	($18.76)	$0.00
Net Income Margin %	***-27%***	***-34%***	***0%***
Increase Required Effective 7/1/24 vs. Status Quo			***34%***

Jeremy Sharp, PhD
He/Him/His
Director & Licensed Psychologist
Colorado Center for Assessment & Counseling
www.coloradocac.com

I'm a psychologist and director of a large practice in Ft. Collins that provides neuropsych testing to families across the state. I'm guessing that the two of you have gotten several messages from other psychologists regarding the Medicaid reimbursement rates for neuropsych testing, and I hoped to add my own data for your consideration.
I'll try to keep it short :)

- we provided about 450 evaluations for Medicaid clients last year in our practice
- Medicaid provides the lowest overall reimbursement rate for evaluations of all our insurance panels. Our primary regional entity (RMHP) is even lower.
- testing is a highly-specialized, niche service requiring a doctoral degree and often a fellowship, yet reimbursement rates are lower than those for an hour of counseling/psychotherapy
- testing is a high-overhead services with a cost of goods sold of nearly 10% on each evaluation we do
- testing is in exceptionally high demand. We're booking into 2024 for evaluations.
- an increase to the following CPT codes would allow us to continue accepting Medicaid for testing. As it stands, the hourly reimbursement barely covers a typical psychologist's salary plus overhead and cost of materials. The increases noted below would give us an additional 3% overall revenue, which is the bare minimum to cover cost of living increases each year.

96132: $147
96133: $112
96136: $67
96137: $54

Jennifer Paz Ryan, M.Ed, Psy.D. (she/her/hers/ella)
Bilingual Co-Founder of Elevated Insights Assessment, LLC
www.elevatedinsights.org

I am writing to you to share information about our practice and how current Medicaid testing rates are not sustainable. I urge you to consider the following information and attached documents as you continue to work with Colorado legislatures to increase their understanding of the unique training and licensure that is required to be considered a "testing psychologist" and the subsequent rates that are needed in order to maintain current specialists, increase workforce, and ensure sustainability. Elevated Insights Assessment (EIA) www.elevatedinsights.org was founded in 2015 by Drs. Jennifer Paz Ryan and Kate Colón and remains a small private practice that specializes in psychological assessment of children, adolescents, and young adults. We opened as there was a tremendous need for assessment with the goal of increasing access to evidenced based culturally appropriate comprehensive psychological evaluation services. We have been paneled with Colorado Health First Medicaid since 2017 and since then have been able to provide high end diagnostic evaluation services for disability determination for developmental disabilities including global developmental delay (GDD), intellectual disability (ID), and autism spectrum disorder (ASD) which often co occur with other mental health conditions and impact functioning across environments. As you know in 2022, there were 1.73 million individuals covered under Medicaid in Colorado. Currently there are approximately 1.23 million people in Colorado who identify as Hispanic/Latino/a/e. 53% of these speak Spanish to some degree (many monolingual and some bilingual). Across metro Denver, there are only three bilingual and bicultural licensed clinical psychologists who have private practices specializing in Spanish assessment for ASD with 98% of their Spanish speaking caseloads covered by Colorado HealthFirst Medicaid. The waitlist for

children to access an ASD evaluation at Children's Hospital Colorado is currently 2+ years. There are already too few providers to meet the needs of the ASD Medicaid community and this change would force the majority of providers to no longer provide these services. It is important to note that Medicaid requires a revaluation every 2-3 years to ensure access to ABA services. Medicaid pays out about 50% of what is billed. For example, a comprehensive evaluation for autism takes around 16 hours to complete and is billed at a rate of $200 per hour = $3000. With the current reimbursement rates, Medicaid pays out about $1673 for one evaluation which takes 16 hours, which is about 50% of what is billed and paid by those not under Medicaid. A licensed psychologist who completes approximately 5 comprehensive evaluations a month would earn approximately $92,000, which does not account for any of the overhead, testing materials (up to $200 per client), and benefits (medical/wellness) that are needed in order to run a small business. In Colorado the average salary of a licensed psychologist is $97,000. This is before the niche training and expertise needed for psychological assessment delivered in another language is included. Our company completed ~550 evaluations for those with Colorado Medicaid last year with 240 of those provided in Spanish.

Current Medicaid Testing Rates:
96136: $64.82 (one unit first 30-minutes direct testing- requires niche training)
96137: $47.44(30-minutes additional units direct testing- requires niche training)
96132: $126.03 (one unit first 60 minutes testing battery planning, reviewing documents, determining medical necessity- requires niche training)
96133: $99.82 (scoring, interpretation, synthesize and analysis of data requires niche training)
90791: $156.98 (1 unit intake- can be conducted by a variety of professionals)- This rate is more disturbing for me and further emphasizes the point that those setting rates do not understand the value of nor the expertise of testing psychologists. The current rates (above) are not sustainable, and we stand to lose ~$163K this year (2023) with current rates.

We have identified that a rate of $131 per hour will cover a 5% profit and a rate of $134.75 will cover a 7% profit (which are minimal) just for 2023! The cost of living in Denver is ridiculous (5% over national average) and we need to be thinking about sustainability for the next 3 years. Therefore, we require a substantial increase in current rates that come to at least the 90791 rate of $156.98 per hour as this has been considered the rate for intake which can be completed by "any" level of professional. This rate would cover the cost of inflation and cost of living and ensure equity. We also request that a modifier be added at a rate of $50 per hour for psychological testing services that are completed in another language (such as Spanish) which would greatly reduce the cost of interpretation services and also address issues of equity.

I am attaching budget sheets from our practice for your review. It is clear that those that are setting the rates do not have a good understanding of the level of expertise that is required for psychological assessment, nor the associated time, costs, and training that is required for comprehensive evaluation services. A good diagnostic evaluation will ultimately reduce the cost of treatment and resources that an individual will utilize over the course of their life as it can target specific treatment recommendations and interventions that will lead to maximum independence. I along with several other local experts in this field would be happy

to provide you and your team with a deeper understanding as to why these are such a valued resource for our Colorado community.

Tricia Mettler, LPC

I understand there is a meeting on September 29, 2023 to review behavioral health fee for service rates. I'd like to discuss the 90876 cpt code rate for biofeedback/neurofeedback. Currently, it's considerably low, despite my substantial investment of over $12,000 in training and equipment, with ongoing expenses ahead. The clients I work with wholeheartedly endorse neurofeedback, attesting to profound, life-changing improvements acknowledged by their loved ones. I, too, have witnessed remarkable progress in my clients. Historically, the 90876 rate exceeded that of 90837. However, this has since changed, posing financial challenges for me. Despite these obstacles, I'm committed to continuing to offer neurofeedback, firmly believing in its transformative effects and benefits. The cost and the reduced rate, though, make this pursuit more challenging.

Joshua Drayer
Lauren Millard
Alex Buscaglia
Camille Brunel
Marlee Lederer
Amy Patinella
Christen Misra
Jennea Abell
Brienne Brown
Taylor Miklos
Orphea Wright
Samantha Walsh
Dr. Kaity Brock
Colleagues at Colorado Therapy & Assessment Center
ColoradoTherapyAssessment.com

Dear MPRAC & HCPF members and representatives,

I, along with many providers in the community, are concerned with the proposed changes for Medicaid billing for psychological assessments. Medicaid providers are alarmed that HCPF has, by fiat, after ignoring an outcry from providers, moved management of autism testing from "medical" to "behavioral health." We are very concerned about ASD testing moving from HCPF Medical to the RAEs. We oppose this and respectfully request that the RAEs refuse to take on management of ASD testing. Autism is not a behavioral health disorder. RAE organizations are contracted to manage behavioral health services, not medical testing. We have raised the alarm about this concern since at least April 2 of this year (to RAEs, HCPF's Eddleman, Bates,

Laukkanen, Governor's Office, Representatives Young, Amabile, and Michaelson-Jenet and Senator Kolker).

Besides violating Colorado Parity law (HB19-1269) through unregulated rate setting schemes, HCPF regulation of RAE management of the Medicaid system has repeatedly failed Colorado and its mental health care providers and clients, including their return of $99 million to the state unspent in 2022, as Rep. Sirota inquired about in March figure fixing.

Additionally, HPCF has already lowered the reimbursement rate for autism testing in July. The rate decreases for psychological/neuropsychological testing while increasing therapeutic rates is extremely disrespectful and demonstrates the value in generalist care rather than specialty.

This means a whole workforce of neurodivergence experts will no longer offer testing for autism as the rates are already low and now even lower. Additionally moving from medical (Fee for service) to RAE (multiple contracts, long wait times for contracts, variable rates from RAE to RAE, long payment cycles, inadequate provider support), means providers will simply quit the system.

I am incredibly invested in these issues of equity and accessibility, while also maintaining the integrity of training and expertise.

Thank you for your consideration.

Pediatric Behavioral Therapy (PBT)

Amanda Mellot – Action Behavior Centers

We have a lot of providers on this call for Pediatric Behavioral Therapy. They had some questions and were looking at a potential emergency rate adjustment and that this meeting would be held and there would be a decision at this meeting. Wanted to get an understanding of where we sit with pediatric behavioral therapy. Any of their providers would be happy to provide any data. Would provide details in writing to the Rate Review Email Seeing a lot of her colleagues in the chat for ABA specifically around wait list for autism from several months to a year and are worried. What advice would you give? Moral quandary because they have to continue to see patients, but they can’t sustain their business. They need guidance from the department on what to do – Kevin from HCPF referred Amanda to the appropriate policy folks, and will bring policy staff to next meeting. Victoria from HCPF stated this group does not have authority to make emergency rate adjustments, explained MPRRAC process with MPRRAC Member Kate voicing support for both providers and MPRRAC, explaining the process as well as giving other advocate opportunities.

David Breidis – Behavioral Innovations

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They [Behavioral Innovations] are one of the largest providers in the state and operate 8 centers currently, and they are not profitable in this space. As a result, they are forced to have challenging conversations about exiting the state. They want to continue to serve the Colorado Medicaid Community

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Ken Winn – Colorado Behavior and Learning Group

There are several issues going on – there are several issues here including the denial of services. It's already been mentioned that they are seeing providers leave because of these issues, but it's a dangerous state where the individuals (CDC came out with 1/36) are increasing, but we're seeing the opposite trend in services and providers being able to serve them.

David Hatfield - Oliver Behavioral Consultants

What led a lot of people here is that they didn't know what MPRRAC was in 2019 and they missed the boat in order to provide information. They are really wanting to make sure they don't miss the boat. If they continue to miss the boat, this program will fall. They have so many people and so many resources that they can/want to contribute to help the committee understand.

Multiple stakeholders presented similar comments with the below main themes: There were eleven (11) public comments. All felt a rate increase was needed for PBT. Most commenters shared that PBT providers are leaving the state or limiting services for Medicaid due to low reimbursements. Recommendations included: comparing to Tri-Care rates, looking at states like California (who did not increase rates and is seeing negative impacts) and Nevada (who did increase rates and is seeing positive impacts). Texas has seen low uptake because rate is low. Specific codes mentioned were: 97151, 97156, 97153 (80-90% of billable hours – is at 77% of TriCare), and 97155 (2nd most utilized code – 69% of TriCare)

JJ

Please raise the rates so that we can attract and retain talented therapists.

Amanda Mellott

My name is Amanda Mellott, and I represent Action Behavior Centers. I have worked in the field of Applied Behavior Analysis (ABA) for over 7 years, and started as a floor therapist known as a Registered Behavior Technician. I've seen the positive outcomes of ABA Therapy on children diagnosed with Autism, and I'm advocating for the behavior analysts and technicians providing excellent care to these children in need of treatment. I'd like to start by saying that we are very grateful the Committee is willing and able to hear our plea. I've already provided write up with pages

of data and facts about the impact and importance of ABA therapy, as well as a cost-benefit analysis with numerous studies citing that investment in ABA can save the state millions of dollars per child. I think we can all agree that ABA therapy is vital to our community, and no one here can doubt its efficacy—so I wanted to leave you with some major sticking points of what is impacting the Colorado area right now for access to ABA via Medicaid:

1. There is a drastic rise in inflation in Colorado.
    a. Inflation alone is up over 10% year-after-year according to Consumer Price Index Reporting--which does not include the most expensive and purchased necessities of all; food and energy. The increased labor costs on the Colorado market – e.g. The city of Denver raised the minimum wage 11%, and is now 26% above the state minimum (on average).
2. Various ABA providers leaving Colorado at this time (mass exodus of failing larger ABA providers).
    a. The state of Colorado has lost 6 major ABA companies in the past year, with 5 others rumored to be currently considering shutting doors. This is due to cost of living constraints: The reality is--providers cannot afford to live in Colorado anymore with rising cost of living, expenses, and low reimbursement rates for the services they provide. While the supply and demand is drastic in Colorado, there are other states offering more fiscal and resource incentives for providers to uproot and move.
    b. Additionally, cost of living and cost of keeping clinics open compared to reimbursement availability in Colorado is substantially lower in other states--and therefore has forced the hands of many providers' and major ABA organizations to focus their resources elsewhere.
    c. I hope this comes off appropriately, but in no instance should a mental health practitioner and their team of paraprofessionals be in a situation where they make less than a barista at the coffee shop down the road or the local fast food restaurant, per hour. For reference (the floor is hovering about $25 per hour).
3. Board Certified Behavior Analyst (BCBA) Count is "Lean" in Colorado, compared to other states.
    a. Currently, there are only 2.16% of the Nation's BCBAs currently practicing in Colorado--which means that practices are working very "lean" and still providing high-quality ABA Therapy to children with ASD.
    b. These providers should be incentivized for these achievements in an over-inflated market, given respective large-scale states with insatiable demands like California (8,325 BCBAs, or 13.88% of total BCBAs), Georgia (1,269 BCBAs, or 2.11% of total BCBAs), Florida (5,591 BCBAs, or 9.32% of total BCBAs), Texas (3,388 BCBAs, or 5.64% of total BCBAs).
4. Various other Medicaid entities across the United States are raising reimbursement to meet the growing demand for services, as well as inflationary markers.
    a. For example: Nevada: The state of Nevada just issued for the 2023 calendar year $30 per unit (or $120 per hour) for Medicaid providers, for CPT Code 97153 - Direct, 1:1 ABA Therapy with a Behavior Technician or Registered Behavior Technician.

Resulting in Positive Outcomes: Currently, providers are flooding enrollment with Medicaid to help serve the populus, and Nevada Medicaid has shown with their routine data that this decision has already been beneficial to their members' treatment, seeing positive outcomes, and the graphs/data they provide on their website shows a strong correlation that the state funds they invested in provider reimbursement for ABA therapy has been beneficial to the long-term fiscal outcomes--which we know from other research that this is supportive of saving the state millions of dollars from reduced hospitalization costs, reduced long-term care supports, reduced state costs for special education, etc. (see research under section The Cost-Benefit Analysis of ABA Therapy on the long-term dollars saved by the state due to early, comprehensive ABA Therapy)

California: With the lack of increases in reimbursement for Medicaid, rate cuts for commercial insurance in California, and rapidly increasing costs of living--various providers are fleeing out of the state to treat the population in different regions/states that are willing to reimburse providers for the value of their services.

Resulting in Negative Outcomes: Medicaid in California have deemed it a state of emergency due to lack of providers, and an already 1 year+ waitlist, ending up in 2+ years for delaying treatment. CASP is currently involved with providing the providers left in the state guidance, while advocating for families and providers alike in this
treatment "drought" where various large-scale ABA providers have left due to the rising costs of care and no help from the Managed Care Organization (MCO) Payors--as they were responsible for managing behavioral health reimbursement. Medicaid of California's stance on this matter is,"Mental Health Plans negotiate rates with and reimburse individual network providers and are not required to reimburse network providers at the rates posted..." Medicaid still has not intervened on the matter, and more providers leave the state each day. This stance has been detrimental to the welfare of thousands of children diagnosed with Autism in California, their families, and the careers of these providers--which trickles down to impacting providers' families as well).

Patient Testimony (with no PHI): We've seen this play out; we have families who have uprooted their lives and quit their jobs in California so their children could receive treatment at Action Behavior Centers' clinics in other states (e.g. Colorado, Texas, etc.), simply to receive access to high quality ABA therapy. We give these two examples to show how two states have responded to the same problem--with
dramatically different results. As you can see, the route that Colorado is currently heading down is one similar to California--and an alignment of approach similar to that of Nevada would be ideal for all parties involved, and to mitigate the current influx of ABA providers/organizations being forced to leave the state or stopping providing care to Medicaid patients, simply to put food on their tables.

Pricing data shows that the prevailing average for Colorado Medicaid reimbursement is far below what is offered by commercial entities. Times are tough, and when that

happens--people are forced to make difficult decisions. I'm not promising this will happen, but we've seen it in other states already that this may force providers' hands to start looking at focusing on the commercial market demand as an equi-exchange for market demands to reimbursement ratios to simply keep food on the table for themselves and their families.

Ken Winn

Rates continue to be an issue that is decreasing capacity, especially for those with complex behavioral issues

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Shasta Brenske

Pediatric Behavioral Therapy Providers are struggling to continue providing therapy services without an increase in the reimbursement rates. The rates in Colorado are not sustainable to maintain the labor cost necessary to continue to provide those services. I would like to propose that the committee look at comparing Tricare West rates as an example for rate ratio comparison. The two main billing codes utilized in this model are 97153 and 97155. The 97153 Medicaid rate is 13.97/18.15 (Tricare)=76%, The 97155 Medicaid rate is 21.80/ 31.63 (Tricare)=68%. Already providers are dropping Tricare as a funder due to their rates being too low to maintain costs associated with providing services. Additionally, I would like to propose including 97156 as a reimbursed CPT code as this is an essential service to providing therapy that is not currently covered by CO Medicaid.

Abbie Koenig

For PBT, the switch from moving providers out or IDD waiver services to EPSDT services in 2019 was dramatic. While there were positive outcomes from this adjustment as well that many of us cheered, the financial impacts on organizations were dramatic. With a 48 hour notice, we received a 40% cut to our most common service rate, and many of our services that previously had a code we could bill for were no longer covered at all, so those required services had a 100% reduction. Since this rate cut, we have also had an increase in employee costs of greater than 30%, making the model unsustainable under current reimbursement rates for agencies that serve Medicaid clients primarily. Providers that served under the IDD waivers services were automatically enrolled as PBT providers during this 48 hour shift, so I suspect there may be some discrepancies between enrolled providers versus providers actually accepting Medicaid clients. There are some agencies who will accept Medicaid clients with a cap of 20% to 40% and are able to sustain. Our organization is the one and only PBT provider in many of the rural counties in Colorado that we serve, and in these regions, more than 90% of our clientele who are Medicaid recipients, making models for serving rural communities (or other primarily Medicaid communities) dramatically more challenging than in locations that have a greater payor blend.

Dave

1. NPIs for ABA providers are being used by ABA providers in EPSDT.
2. There are 5 categories of providers in the PBT lead category with very different qualifications and training requirements.
3. Furthermore, when the Waivers moved Behavioral services in 2019, prior to the first MPPRACreview that none of us know about, EPSDT imposed a 32% rate cut on the Masters/Doctoral staff.
4. This group continues to be 35% lower than BA [and MA, and Doctoral level providers as they are all paid at the same rate] Speech Pathologist and Occupational Therapist.

Rebecca Powell

The cost of doing business in CO has skyrocketed since EPSDT's inception in 2019. Data indicates over a 43% increase in cost of doing business directly related to laws being passed in CO regarding minimum wage, sick leave, FAMLI act, etc, however reimbursement rates have only increased a total of 4.3% since 2019. We have lost 6 companies in CO in the past 18 months as a result and several more are having to turn away Medicaid families or significantly reduce the number of Medicaid patients they accept because the rates are unsustainable. Primarily, severe behavior patients are going unserved due to these ongoing rate issues as they are the most expensive patients to treat. In addition, Medicaid did not adopt all of the AMA billing codes for ABA including the caregiver training billing code, yet we are required to have caregiver goals and to report progress on caregiver goals in each progress report on a 6 month cycle, yet we are not reimbursed for this time spent teaching caregivers to implement protocols. I am not aware of any other state that also determined to make the assessment code an untimed code which does not align with AMA guidance. Commercial insurance allows 8-10 hours of assessment whereas the Medicaid rates come out to about 3.5 hours of BCBA time. When you then add in time spent managing all of the Kepro pends for information and denials (often erroneously) this increases our time spent to over 20 hours per patient per assessment. This means Masters level clinicians are reimbursed at $16-21 per hour which is simply not sustainable. We need both adequate rate increases to sustain our businesses and full adoption of AMA codes to eliminate the disparity CO Medicaid families experience as compared to commercial insurance families. Plainly stated, CO Medicaid families are receiving lower quality care (if any care at all) due to the many barriers that currently exist.

Dr. Nichole Swann

I am incredibly concerned that rates and guidelines are being developed and followed that do not accurately reflect the needs of Colorado specifically. The states referenced as standards from which rates were established and processes by which were adopted are not congruent with the needs of Colorado. Our cost of living is higher, as is the reimbursement for the providers hourly wages. We have unique minimum wage standards, which I know these other states do not, specifically Utah and Louisiana. I believe the administrative aspects of running these companies and associated costs are not being accounted for. I would say there is a

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fundamental lack of understanding of what we do and what our programs entail. We need at minimum a 15% increase in rates to keep going.

Andy Li
Mindcolor Autism

There are many factual inaccuracies in the analyses. For example, on page 44, the Tricare rates presented are way off and outdated. The latest rates are in the file linked here and for the 97153 code it is ~40% higher than what is presented: https://www.health.mil/Reference-Center/Publications/2023/06/01/ABA-Maximum-Allowed-Rates-Effective-May-1-2023 Additionally, the 7 states used as peer group seems arbitrary and artificially suppresses the median rates. If we are using geography as a metric, then Nebraska and New Mexico should both be added to the peer set given they are neighboring states. We would be happy to help with the analysis if that would be helpful.

Ian Goldstein
Soar Health Inc d/b/a Soar Autism Center

- Tricare rate benchmark data for PBT appears incorrect, should be $18.15 for 97153 (see here).
- Utah rate benchmark data for PBT appears incorrect, should be $17.92 for 97153 (see here)
- Concerned about Department's use of an 80-100% benchmark methodology to set rates. Typically Department compares CO Medicaid to MediCARE, looking at 80-100% of MediCARE for a given code, which is a reasonable approach. The challenge is PBT/ABA has no Medicare codes so there is no Medicare comparison. Instead, this analysis compares CO Medicaid to other state Medicaid, assessing if Colorado within 80-100%. We believe this is a flawed approach, as it adds a 0-20% haircut on other states' Medicaid, which are already low. It's a "haircut on top of a haircut" approach. The net effect is leaving CO Medicaid with substantially low rates relative to cost of quality care, and providers are existing the state

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Dr. J.J. Tomash
BehaviorSpan

The ABA provider crisis is deepening every week, and I want to present information that speaks to the emergency we face as a state.

Ken Winn
Colorado Association for Behavior Analysis

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We will be providing input tomorrow for the meeting tomorrow where we will be discussing rates for Pediatric Behavioral Therapy and the "holistic" approach with COABA. We are concerned that the data presented is grossly inaccurate. Providers are leaving the state in droves, mainly because of the rates for PBT services. See below:

https://bhbusiness.com/2023/07/12/hopebridge-ceo-low-medicaid-rates-inflation-costs-give-aba-provider-no-other-choice-but-to-pull-out-of-colorado/?fbclid=IwAR3LwsiK1xCgdhkppDRRAUirh9MlRDlJhJtqqXHikIJlEmiW1zD2Fo2M3sg

It is not an overstatement to say this is a crisis in Colorado. Many vulnerable Coloradoans with Autism Spectrum Disorder, and related conditions, are less likely to receive this important service and those on wait lists will have to wait even longer for the few providers still providing services. A rate increase is needed IMMEDIATELY to prevent even more providers from leaving and preventing clients from getting the services they so desperately need. I will be speaking on behalf of COABA to address the need for an emergency increase in rates as well as the inaccuracy of the data presented. We at COABA appreciate the ongoing collaboration with your committee and look forward to the opportunity to provide input at the meeting tomorrow.

Allyse Eide
Hopebridge Autism Services

I am a BCBA with Hopebridge Autism Services. My clinic is closing on August 11th 2023 due to reimbursement rates not matching the Colorado inflation rates. There are eleven (11) current families losing services and will be put on long waitlists until they are able to continue ABA services again. There are also seven (7) families who completed the initial ABA assessment expecting to be onboarded in the next few months and have to restart the process all over again. This lack of change in reimbursement is vastly impacting my patients, families, and staff. I have had many caregivers and staff members crying on my shoulder over the last few days since the closure of my clinic was announced last Tuesday 7/11/2023. We need your help to increase reimbursement rates immediately. We need a solution for continuity of care to keep our doors open or to open a new clinic for these families.

Rebecca Urbano Powell
Seven Dimensions Behavioral Health

I would like to present a slide deck that shows the accurate rates for PBT across other states. The MPRRAC deck has old data. I also have information on cost of living, etc that is important to consider.

Erin Keup
Hopebridge Autism Therapy Centers

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I currently work as a BCBA at Hopebridge in Colorado Springs and would like elaborate on the ongoing impact the unsustainable medicaid reimbursement rates have had on our client's families in my area. With Hopebridge withdrawing all ABA services in the state on August 11, this is now leaving many families with no place to go. I have 11 current families that I want to help support in this difficult transition process, as well as several on the waitlist expecting to receive services in the next month. Wait lists at other ABA companies are outrageously long with some approaching 12 months. The quality of care us ABA providers want to provide these families with is declining as the reimbursement rates do not even cover wages to retain RBT's, enriched environments, and educational supplements and tools.

Brad Powell
Seven Dimensions Behavioral Health

- HCPF PBT Rate Analysis is inaccurate (examples below) - Utah 97153 reimbursement is 91% higher than HCPF rate analysis - Utah 97151 reimbursement is 81% higher than HCPF rate analysis - CO TriCare 97153 is 45% higher than HCPF rate analysis
- Colorado Medicaid requires PBT Providers to provide deliverables but Medicaid does not reimburse for required deliverables
- Nine (9) PBT Providers have left Colorado this past year leaving an estimated 650-1150 patients without care
- The #2 PBT Provider in Colorado is leaving the state due to inequality of Medicaid reimbursement rates compared to other states served - https://bhbusiness.com/2023/07/12/hopebridge-ceo-low-medicaid-rates-inflation-costs-give-aba-provider-no-other-choice-but-to-pull-out-of-colorado/

[REDACTED due to HIPAA]
Hopebridge (parent)

My son has severe Autism and had been in ABA for the last 2 and a half years and as made amazing progress. He went from being completely non-verbal to having over 40 words. He was potty trained in a matter of months! He has learned to not cause self harm due to not being able to communicate. He has learned how to interact with other children. He is currently learning how to get over his sensory sensitivities so that he can brush his teeth, get a hair cut, take a bath, tolerate clothes touching his skin, clipping his nails, blowing his nose, washing his hands, and wiping his butt after using the restroom. All of these basic necessities are extremely difficult for him and take months to work on. He is learning how to be in a classroom like setting so that he can transition into a public school next year for kindergarten. He is learning how to deal with his emotions and how to use words instead of violence when things don't go his way. Really I can go on and on about the benefits that ABA brings to him. But it's not just him. ABA helps the whole family. His siblings, me and his father and bonus father are all learning how to deal with my son and his condition. That is something that no where else can give you. ABA provides the whole family with tools to make every day

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life bearable. These BCBAs and RBTs dedicate themselves to make a difference. It takes a special kind of person to Indore what it takes to make these children successful. They must have 8 plus hours of energy to keep up, they must take the occasional beating from a child, they have to have patience of a saint, they have to be vigilant, and above all else they must have a heart of gold. It's crazy to me that the people who take on so much and are making such a difference in so many lives can barely afford a roof over their heads or food in their belly's. Not to mention having any sort of extra income to be able to spoil themselves on the weekend when they most certainly deserve it. Without ABA I don't know if my child will have a future. I don't know if he will make it through school, make it through life. How will he be able to support himself if he doesn't have the skills to land the most simplest jobs? How will he ever be capable of living on his own? As Government officials are you really wanting these kids to live on disability forever? Do you really want to watch the future generations struggle because a huge percentage of our population is incapable of being functioning members of society? It's so much easier to help children than adults because their brain is still developing, so why wouldn't you want to spend money to insure the future generations can function as adults so your not having to pay disability for the rest of their lives? Don't let these children, their families, and the people who give up everything to help them suffer because of money. Think about the return investment.

Brady Perrigo
Shandy Clinic

Behavioral health clinics are closing at an alarming rate in Colorado due to the reimbursement rates not nearly covering the aggressive increases in costs our industry has experienced over the last handful of years. Labor has become prohibitively expensive (up over 50%!), and our industry is now competing with fast food, gas station, and other minimum wage industries for inexperienced people. Increased reimbursement rates will help us hire qualified talent - talent that *should* be working with our children - to properly serve our families and expand our recruiting beyond a low-skillset and unmotivated labor pool. This will ultimately drive better care and results for our pediatric patients. Other exorbitant cost increases, such as real estate, supplies, and utilities expenses, continue to put an enormous amount of pressure on the businesses within our industry. Children continue to suffer while on ever-growing waitlists and need our help now, and it is becoming increasingly difficult to receive the care that they need as so few of us have stuck around to absorb the losses to make sure we continue to serve the families within our communities. What's even more worrisome is that even larger national firms refuse to enter Colorado due to the dynamics at play, and the majority have either ceased operations in the state or have plans to cease operations in the state over the remainder of the year. How will the local "mom & pop" providers possibly survive this? The problem is compounding, and immediate action is needed before it becomes irreversible.

Jennifer
Elevated Insights Assessment

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Would like to discuss the need to increase the rates for psychological and neuropsychological testing AND for adding a modifier that allows for multilingual clinicians to charge $75 per 60-minute unit for equity.

Alexandra Tomei
BlueSprig

I would like to discuss the metric that 85% of providers are participating in PBT. In the last year and a half, 9 ABA agencies have closed their doors to Colorado (many while remaining open in other states) greatly reducing the ability of children and families to access services. There is a lot of data available as to why, but I want to know how you are verifying that there are enough providers, when it seems providers are leaving in droves. I estimate that this is impacting close to 600-900 families this last year and a half alone, and the companies that are staying already had waitlists. What are we doing do get services to these families and ensuring more quality agencies don't leave the state?

Amanda Mellott
Action Behavior Centers

Low reimbursement rates have led renowned providers like CARD, Invo Healthcare, and Hopebridge to close their doors. Countless children with Autism are left without vital therapy, while providers are forced to leave for states with better reimbursement. Inflation alone is up over 10% year-after-year according to CPI Reporting. This increase does not even include the most expensive and purchased necessities of all: food and energy. The increased labor costs in Colorado, such as the recent 11% minimum wage raise in Denver, have further strained providers already grappling with inadequate reimbursement rates. Researchers have shown that without effective ABA intervention, individuals with Autism and their families require lifelong support services at an estimated cost of $3 million PER CHILD in the United States, on average. On the contrary, investing in ABA therapy can lead to significant long-term fiscal benefits. However, without providers to serve these children--Colorado Medicaid is facing a crisis of rising lifelong costs to support these children and families. Compounding the crisis, providers are leaving Colorado to serve states like Nevada and New Jersey that have adjusted their Medicaid reimbursement rates to meet market demand and inflationary constraints. This exodus of providers clearly illustrates the need for Colorado Medicaid's data analysis to follow the successful example of these states. We must act swiftly to adjust reimbursement rates and ensure access to crucial ABA therapy. It is imperative that we learn from the effective strategies employed in Nevada and New Jersey to retain providers and address the needs of our children and families diagnosed with Autism. Let us unite to provide hope and support for Colorado's children. Together, we can overcome this crisis and build a brighter future. I’ve submitted a letter further illustrating all of the data in April 2023. Thank you.

JJ Gorsuch

Play to Learn Therapies

I do not want to repeat the points that will be addressed by COABA, but I want to emphasize two points: 1) The points around COL comparisons (and the impact that has in ability to staff and quality of care) and 2) "How long must we wait?"- This crisis is not new...I have personally been involved in similar requests/pleas to address rates for over a year including speaking to this committee and being (incorrectly) redirected elsewhere for redress - please raise the rates so we can pay a working wage and serve the burgeoning need!

[REDACTED due to HIPAA]
Parent of a child with ASD

I want to discuss the compensation rates for ABA therapy institutions in Colorado and why those haven't been increased due to the inflation over the recent years. This is relevant to the recent news that Hope Bridge is pulling ALL of their ABA locations from Colorado due to low Medicaid reimbursement. I want to know what Colorado is doing to fix this, to increase the reimbursements in this area, and to support the growing and already crowded population that desperately needs access to these services across the state. I also want to know what safeguards Colorado is going to put in place to protect the children and families from companies like this pulling out due to your reimbursement quarrels. Personally, my son was only enrolled for 2 days before we received notice that the ABA institution was pulling services from Colorado. Now everyone is having to scurry and delay care to our children while trying to place them in a new facility that has a minimum of 3 months waitlist. It was already stressful getting my son an assessment, let alone enrolled, and now I have more competition than before to get him the care he needs. The State needs to protect us agains the actions of these companies, my ASD child shouldn't have this happen when most neuro-typical children never have this occur.

Sree Kode
Kyo Autism Therapy

I want to reiterate the many comments that have already been made regarding the unsustainability of the current Pediatric Behavioral Therapy rates. Inflation and the cost of labor have increased significantly and the Medicaid reimbursement rates have not kept up.

Dr. Brian Lopez
JumpStart Autism Center

I would like to comment on how HCPF's implementation of ABA CPT codes is a true restriction of practice and how this negatively impacts MPRAC's rate proposal.

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Abigail Koenig
Colorado Autism Consultants

There are fundamental flaws in the MPPRAC data for PBT. If we just take the first listed comparative state for example, Florida, major discrepancies are present. Colorado does not reimburse for the full code set of service while the comparison states do, so the data is not an apples to apples comparison. For example, Florida covers parent training at reimburses at $19.05 per unit. Colorado requires providers to provide this service, but does not reimburse for it, so the comparison is $19.05 (Florida) to $0.00 per unit (Colorado). Colorado reimburses $321.20 for an initial assessment flat rate. Florida offers this per unit for 24 units with an initial practitioner and 16 units with a second practitioner (not covered in Colorado), for a total reimbursement of $652.20, so Colorado total reimbursement is less than half that of MPRRACs first comparative state. 97156 is covered in Florida $19.05/per unit. This service is required in Colorado, but is not reimbursed, so this comparison is $19.05 in Florida to $0 is Colorado. This service averages 2 hours (8 units per week), meaning that PBTs in Florida are reimbursed 152.30 per client per week for a service that providers in Colorado are reimbursed $0 for. The omissions of the full code set in this MPRRAC's data paint a highly flawed picture of actual reimbursement for services for PBT services that are leading to major impacts across the state for services for children with autism and other neuro-divergent populations throughout Colorado.

Laura Franklin
The Shandy Clinic

First of all, thank you all for providing the time for us to comment. My name is Laura Franklin, and I'm the CEO of the Shandy Clinic. We're honored to serve 3,500 children at 11-locations up and down the front range. Simply put: our ABA program is barely financially sustainable. Every day we're heartbroken to hear that providers have been forced to close their doors... While we wish we could absorb their families and patients, our waitlists are over a year long. We are absolutely committed to doing everything in our power to keep our doors open, but our costs have gone up by 20% and our rates have stayed flat, and without significant changes from a payor perspective, we will be forced to reevaluate our strategy. Thank you so much.

Ken Winn
Colorado Association for Behavior Analysis

We would like to emphasize the need for an emergency rate increase commensurate with inflation and cost of living increases, to prevent the alarming trend of providers leaving the state. We can present data to indicate the problems with the data analysis, demonstrating how Colorado rates are much lower than other states, demographically similar to Colorado.

Rebecca Urbano Powell

COLORADO
Department of Health Care Policy & Financing

Seven Dimensions Behavioral Health

An emergency rate adjustment is needed in order to prevent more PBT company closures in CO resulting in thousands more families losing life changing medical treatment. The cost of doing business has increased by nearly 43% according to the data from 2021 to 2022. We have been given a 7.45% adjustment from 2019 to 2022. This leaves a gap of approximately 36%. Then factoring in cost of living being around 4% per year that puts us at 12% in the next 3 years. Minimum wage increases by 9% in January. (43% + 12% + 9%) -7.45%= 56.55% A minimum emergency rate adjustment of 57% is needed. The issues to date have been the short sighted approach Medicaid has been taking to rate reviews and data collection: 1. Their data is inaccurate 2. They don't account for cost of living comparisons 3. When you only look backwards a year you are always going to be behind the 8 ball We have to use the historical data to identify the trends and project into the future for budgeting. Recommendations/Request from MPRRAC: 1) Recommendation for immediate/emergency rate adjustment of 57% to all current codes 2) Recommendation for adoption of the following: a) 97151 assessment revision to adopt the code as a 15 min code as intended with a reasonable BCBA rate of $35.25 per unit with an allowance of 10 hours per assessment. Additional hours beyond 10 per assessment would need to be justified by medical necessity. b) 97156 addition at newly adjusted BCBA rate of $35.25 per unit. c) Addition of mid tier position (BCaBA) with a rate 80% of BCBA ($28.20 per unit) for 97151, 97155, 97156. d) Modifiers for BCBA direct therapy under 97153 to match the full adjusted rate of 97155 of $35.25 per unit and $28.20 per unit for BCaBAs.

[REDACTED due to HIPAA]
Parent of Autistic child/BT in training

My child is 4. He is receiving ABA in the home setting. He will be attending daycare, only by virtue of his RBT attending with him. If he does not have an RBT, our family will continue to miss half our needed income. ABA is the only therapy that has ever addressed his behavioral needs in any effective, and certainly kind, manner. If we lose access to his therapy, our family (and many many others like ours) will have no care for our children and little hope that they will gain in social skills enough to attend any regular care setting.

[REDACTED due to HIPAA]
Hopebridge (parent)

My child has been in ABA since December of 2020. He has learned how to communicate, wait for things, express his feelings, not self harm, use the bathroom on his own, play nice with others, and to acknowledge others. He's been learning how to brush his teeth, clip his nails, use his inhaler, get a hair cut, touch objects with different textures, how to deal with a large amount of people, loud noises, how to interact with animals, how to ask for things and much more. ABA is so much more than a daycare. It's life changing. It's an outlet for families, and a safe place for our children. It's the one place where my son can feel "normal". It's the one

place where I can know is going to help him learn things that I just can't teach him. It's the only place that I know has qualified people to be able to take care of my son and give him the patience's and love that he needs to succeed. The one place that will give me the tools at home to better the care of my child. Without ABA my house is pure chaos, a war zone. And mine and everyone else's mental health in the house suffers. It's like living with an abusive partner that you can't leave. When he isn't actively in ABA he will hit, kick, scream, bite, and pinch me to try and communicate what he wants or that he's unsatisfied. He will also self harm by throwing his head back over and over again until he bleeds or bruises himself. He will kick doors until they fall off of the hinges. He will run away when in public, not caring about cars or anything else that might happen to him. ABA is literally saving his life! He needs ABA or I don't know how he will move through life. I'm so scared that someone will call the cops on him when he's older and that he will be another casualty. Because reality is that children on the spectrum look just like any other normal child and at some point his behavior won't be tolerated by others and in a blink of an eye I could lose him to a police officer who is scared for their life. Or I could lose my child by my own child's hands. ABA needs to be taken seriously and treated as such.

Amanda Mellott
Action Behavior Centers

Low reimbursement rates have led renowned providers like CARD, Invo Healthcare, and Hopebridge to close their doors. Hundreds of children with Autism are left without vital therapy, while providers are forced to leave for states with better reimbursement--like Nevada and New Jersey that have adjusted their Medicaid reimbursement rates to meet market demand and inflationary constraints. This exodus of providers clearly illustrates the need for Colorado Medicaid's data analysis to follow the successful example of these states. Inflation alone is up over 10% year-after-year according to CPI Reporting. This does not include food and energy costs. The increased labor costs in Colorado, such as the recent 11% minimum wage raise in Denver, have further strained providers already grappling with inadequate reimbursement rates. This alone shows a need for a 21% increase just to meet market demands in Colorado, where a 25-30% adjustment to all PBT Codes is essential to keep doors open. The Harsh Reality is That More Children Diagnosed with Autism are Enrolled in Medicaid than Private Insurance A study published by JAMA Psychiatry in January of 2022 shows that children covered under Medicaid are more than twice as likely to be diagnosed with disorders such as ADHD or autism compared with those who have private insurance. Medicaid/Publicly insured children: 1 in 4 children diagnosed with a neurodevelopmental disorder (e.g. Autism) Commercial/Privately insured children: 1 in 9 children diagnosed with a neurodevelopmental disorder (e.g. Autism) Researchers have shown that without effective ABA intervention, individuals with Autism and their families require lifelong support services at an estimated cost of $3 million PER CHILD in the United States, on average. On the contrary, investing in ABA therapy can lead to significant long-term fiscal benefits. However, without providers to serve these children--Colorado Medicaid is facing a crisis of rising lifelong costs to support these children and families. I've submitted a letter further illustrating all of the data back in April 2023. Thank you.

Dr. J.J. Tomash
BehaviorSpan

To be able to provide the medically mandated services that Colorado needs, our Medicaid rates need to increase.

Brad Powell
Seven Dimensions Behavioral Health

An emergency rate adjustment is needed in order to prevent additional PBT company closures in CO resulting in thousands more families losing life changing medical treatment. Issues:

1. HCPF PBT Benchmarks and Rate Analysis is inaccurate (examples below) - Medicare does not fund PBT, so “Rate Benchmark Comparison” uses other states without factoring in Cost of Living
    a. Utah 97153 reimbursement is 91% higher than HCPF rate analysis - Utah 97151 reimbursement is 81% higher than HCPF rate analysis - CO TriCare 97153 is 45% higher than HCPF rate analysis. HCPF Rate Analysis does not consider capped units - E.g. TriCare reimburses assessments 356% higher than Colorado Medicaid after considering unit caps
2. In 2019, Colorado Medicaid cut PBT reimbursement rates by 34%.
3. Colorado Medicaid requires PBT Providers to provide deliverables but Medicaid does not reimburse for resources spent on required deliverables.
4. Ten+ (10+) PBT Providers with dozens of clinics have left Colorado
5. 1000+ patients abruptly lost services this past year
6. 1000+ Colorado employees abruptly lost jobs this past year

Solutions:

1. Immediate/emergency rate adjustment of 57% to 97151, 97153, 97155 codes and give assessment codes 8 hours per cycle at BCBA rate with the adjustment.
2. Adopt code 97156 (Parent Training - for managing behavior at home)

Summary: This will allow us to break even through 2024. This does not even allow for a profit margin. This request is simply to survive through 2024.

Katie Topham
Nest Life ABA

Truly appreciate the fast work to redo the analysis, however I just want it to be noted that there are still codes not included in the analysis. Most notably 97156 - family adaptive behavior treatment guidance which is only able to be provided by the Masters or PhD level

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clinician. Furthermore, is there an update on whether there are options to adjust rates before next fiscal year?

[REDACTED due to HIPAA]
Hopebridge

Concerned parent

David B Hatfield, Ph.D.
Clinical Psychologist and BCBA-D
Oliver Behavioral Consultants, CEO
pronouns (He/Him)

Hi, thanks for your time. I don't know where to send this but was told to definitely get this to you. It seems the format for introducing data can be challenging I'm a Clinical Psy and BCBA-D, so in both worlds. [I apologize in advance for the length of this response. Just don't know how else to share the complexities of the situation. I'm an ex prof that taught Stats and Methods, LOL.] What I noted in the last meeting:

the focus was on folks challenging or commenting on data, not discussing actual rates. We may have been confused as the EPSDT director shared with the PBT group that the reason we didn't get a rate adjustment rec sent to JBC was because no one told MPPRAC in 2020 that the rates were too low. After we asked what MPPRAC was, she said to join this meeting and share our rateconcerns.
The data presented in the meeting, and in the report to JBC appeared limited to 2 types, growth in enrollment by families and growth in enrollment by Providers.
I did comment that the former growth of around 25% by families had no actual data on the number of families in 2021, so 25% growth was really not understandable. for example, If there were 1000 enrolled in 2021, and it grew by 25%, the new enrollment would be 1250 families now. If 500 in 2021, then it would be 650 now. The rate of ASD has grown to 1 in 36 kids by the age of 8 from 1 in 62 just since 2019, which is a more than a 40% increase in incidence. So enrollment growth is not reflecting that increase. When we take the Colorado population of kids served by Medicaid and multiply by this incidence, we should have enrollment numbers in the tens of thousands sadly.... So enrollment numbers are very important Also, if they even receive 1 hour of a needed 30/wk for 52 weeks, or 1 of 1560 hours, they are counted as 'enrolled'. Access to dosage is very important here. On the second issue, provider enrollment growth of again somewhere around 25%, all the same issues apply, and the unit of measurement was enrolled to provide, not actually if they did more than 1 hour of service, or did multiple hours with multiple kids over the course of year. Lots of folks sign up for MDC, find out it is not financially feasible, and immediately quit. So this data is like a partial interval of one year—do it once or do it 500
times, both are scored as a Yes. From the number of company closures and for others, the restriction of MDC to no more than 30% of caseload, and for others, moving to only providing 3 hours of service per week for a kid scripted by Peds to get 30 hours of service per week, the system is collapsing....Gathering these data would be very helpful and more useful than the

current model. I believe other data would also help like a. Effectiveness data showing the lives changed, and the outcomes of medically scripted and necessary services for these kids b. Cost savings by serving the kids now instead of over the entire course of their life c. Tax base earnings due to parents being able to work instead of staying home caring for their child to adult indefinitely d. Tax base earning due to kids learning to become happy and contribute to the job market themselves. About 50%.

J.J. Gorsuch
(he/him/his)

Thanks again for the discussion on 4/21 and all your efforts in the Rate Review Process. I was reflecting on the discussion and then looked at the minutes from that meeting and wanted to offer two corrections (below). As stated, the purpose of this meeting was to clarify and understand the data, so I think it behooves you to ensure the committee is well aware of the possible discrepancies in the benchmark data.

1. There seemed to be some misunderstanding among some of the committee members of a historic 'rule of thumb shooting for 80-100% of the benchmark'. While I am familiar with that rule of thumb having attended a few of these meetings now, it would ONLY be applicable to the benchmarks that are based on MEDICARE rates. In the case of the Pediatric Behavioral Therapy (PBT) discussion, I think based on the discussion that it was missed (by at least some members) that that benchmark was constructed from other states' Medicaid rates, because there are no Medicare rates for these codes. That it was missed is understandable but it should be clarified to all the MPRRAC members that the 'rule of thumb' wouldn't be applicable in this case and that we (as a State) should probably shoot for >100% of the benchmark in this scenario of comparing to other State's Medicaid.
2. The minutes seem to specifically elide the discussion points made around the inadequacy of the States chosen for the benchmark for comparison based on Cost of Living Index. Many of these comments were in the Chat... The gist of the points were that it was unclear why those 7 States were chosen but that 6 of the 7 Benchmark States are below Colorado in ranking of Cost of Living Index. Obviously this would suggest that the committee should consider being well-north of that benchmark or that the benchmark itself should be adjusted for COLI. This was an important point of the discussion that should help the committee understand the data presented that seems to be missing completely from the minutes...can you please include in the minutes and share with the Members?

Andy Li
Mindcolor Autism

I wanted to clarify a sentence from "next steps" ofbthe most recent rate review advisory committee meeting on 4/21. Could you clarify what was agreed on with PBT providers

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represented on key action areas toward a potential July rate change? It seems like there were some follow ups to review the analysis but I did not see any action items in terms whether a decision will be made prior to or during the June meeting. Thank you!

Emily Ice, Ph.D., BCBA-D, LBA

PBT rates do not have comparable Medicare rates. Additionally, comparisons with other Medicaid states would not be a fully accurate picture because CO Medicaid has several barriers that require providers to absorb additional costs for service provision. Finally, the comparison of NPI providers is inaccurate as well, data has shown that there is at least a third reporting error with Behavior Analysis NPI alone. These avenues to rate setting will not allow the committee to accurately identify the needs to maintain provider adequacy in CO. Rather, cost of service provision will need to be considered. Providers are happy to provide the information necessary to allow this to occur and the data has already been presented to HCPF's PBT Representatives including the Division Director.

Todd Addleson, MS, BCBA
CEO
Pronouns: He, Him, His

In the rate review committee meeting today it was shared that current Pediatric Behavior Therapy rates are at 92% of "Medicare Benchmark" but it was then explained that this comparison was actually based on comparison to Medicaid rates in 7 other states. All seven states have lower cost of living scores that Colorado. Given that Medicare rates do not apply, it seems critical to find a better methodology to give any kind of reasonable benchmark. Either include Tricare or commercial insurance rates specific to our geographic region, or adjusting/weighting state medicaid rates based on COLI. Colorado's COLI score, 114.4, is 13th highest in nation. Louisiana: 91.6, ranked 6th lowest; Nevada: 103.4, 31st highest; North Carolina: 94.6, 12th lowest; Utah: 102.9, 29th highest; Washington: 112.1, 17th highest; Texas: score of 96.5, 24th lowest; Florida: 99.2, 23rd highest

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Dr. J.J. Tomash
BehaviorSpan

Please accept the following statement for consideration in your decision on whether to adjust Medicaid rates for EPSDT services. I am very proud to have served the ID/D community in Colorado for more than 8 years as a provider, including 7 years as a business owner. Colorado's Health Policy Office has demonstrated a commitment to serving children with ID/D, regardless of their family income. This commitment has created a unique ABA provider culture in Colorado- full of passion, pride, and innovation. MY company, BehaviorSpan, was founded in Colorado and has served the Denver area for 7 years with a mission to provide the best ABA services available, regardless of the income of the families we serve. We serve almost

exclusively Medicaid clients, and we provide lunches at our own expense to clients whose families are unable for any reason to send them to our center without lunch. Since I began providing ABA services in Colorado, I have always had an op9mis9c, progressive view of the future of services in Colorado: assuming we would con9nue to improve services, and in the near future Colorado will be a shining example of what can be accomplished for citizens with ID/D through intelligent and targeted expenditures of state funds. I am optimistic about our future. However, I am deeply worried about the timeline of progress. I am alarmed at the rate that providers are leaving Colorado. I am also alarmed at the rate that outside investors and providers I am in contact with have cooled on the idea of entering Colorado. The prospect this presents to families looking for ID/D services, like the Early Intervention ABA we provide, is that they will be facing a future in which less services are available, not more. The real effect of this is devastating to families. From what I have seen in my 9me as an ABA provider in Colorado, this last year has been the most challenging I can remember for families of children with au9sm and developmental delays. It is hard to get ABA services. Finding available spots in ABA programs has become a desperate situa9on, as waitlists among local companies have grown to months and even years. Just from the network of ABA business owners I know, the waitlists range from 2 months up over a year. This is a very long time for a parent to wait to get their child into therapy. For younger children, who are in the most important 9me of their lives for development, this is time lost that will never be regained. These waitlists con9nue to grow. From my own experience and that of every other provider I have talked to, our greatest challenge is hiring and retaining staff. Our profit margins are lean at the best of times, but with the increase in labor costs it has become very difficult to bring in new therapists. My company has lost multiple staff in the last 2 months who simply went to another field where they can earn more money. Hiring is just as challenging, as we are competing with other healthcare and service industries that can afford to pay more. I have spoken with many other providers, and this experience is common. Many other ABA providers are struggling worse than we are. The quickest, and most direct way to overcome this situation and meet the skyrocketing demand for Autism services in Colorado is to make the field of ABA Autism treatment more competitive on the labor market. The only source of income for this field is 97153. Increasing the billable rate for 97153 would allow us to pay our staff more and bring in more clients. This change would have an impact across all ABA providers in the state, and would allow our waitlists to begin to shrink again. Colorado is not the only state with this challenge. New Jersey faced a similar situation to ours, and responded by increasing their rate earlier this year from $44.80 to $60 per hour. According to Autism New Jersey: Families were not able to get ABA services, and expressed a great deal of frustration (they had waitlists equivalent to ours from what I've heard from providers in NJ). Upon looking into why ABA services weren't available, they discovered that the low RBT rate meant that providers were losing staff because they couldn't afford to pay them more. To solve the problem, they gave providers a 36% rate increase, which has been very favorably looked upon and has made a massive impact in the availability of services. Another example that of Nevada. I have attached a report written by a provider last year in Las Vegas. I was astonished to see that the financial situation that the provider describes is nearly identical to that of our company and others in Colorado. The only difference is that Nevada has a 7.2% lower cost of living than Colorado does, and the expenses here are much higher than those reported in the Nevada report. Aside from this, the report mirrors our situation here. Of our neighboring states (Arizona, Wyoming, New Mexico, Nebraska, Utah), the average reimbursement for 97153 is $59.44. While Colorado is lower than this ($55.80), we also have the second highest Cost of

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Living of those states (8.52% above the national average). Based on what I have seen in these two states, from providers in Colorado, and our own experience, I would like to make the following proposal: The reimbursement rate for 97153 should be raised by 23% to $68.73. This number is arrived at by taking the regional average rate for 97153 ($59.58), and accounting for Colorado's higher Cost of Living than the comparison states around us. This rate is specifically calculated to:

1. Make Colorado comparative with surrounding states, even when accounting for our higher living expenses. This avoids us having to ask Behavior Technicians to make a financial sacrifice to provide their life changing services. https://autismnj.org/news/autism-new-jerseys-advocacy-leads-to-medicaid-rate-increase-for-aba-services/
2. Reward providers and incentivize the further development and expansion of our ability to provide these services.
3. By making Colorado more competitive, it avoids parents having to consider moving to another state to be able to get their child into the services they need. Colorado is facing a quiet crisis for parents of children with Autism. They are referred to ABA services by their healthcare providers, only to find after calling ABA providers all over town that they will be waiting several months before services can begin. During this time, their child is losing perhaps the most valuable time of their life to be learning, and their behavioral challenges are growing and becoming more ingrained. As discussed above, the root of this crisis is a staffing shortage- and Colorado is not the only state facing it. Other states have had similar crises and have met the challenge by increasing the reimbursement they are willing to give their providers. In this proposal, I have suggested an increase of 23%. This increase is small compared to what other states have implemented (66% in Nevada, 34% in New Jersey). Colorado has a history of valuing our services, which we are grateful for. I hope that the state will continue this tradition by realizing that today it is time for a course correction, and many children and adults are desperately relying on it.

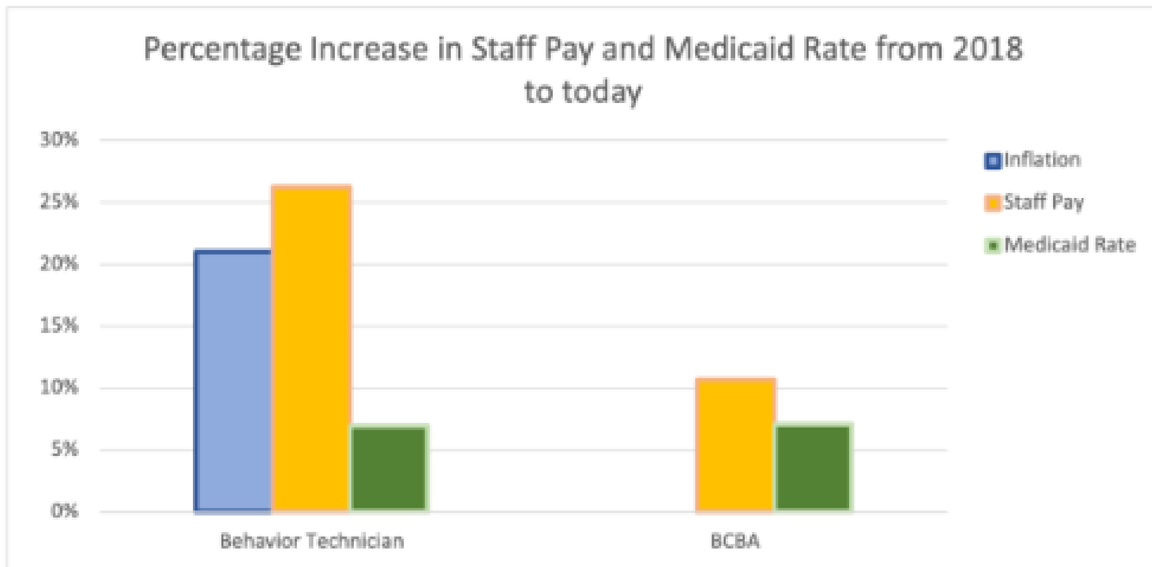
Ryan Thurber
Shareholder
he / him

My name is Ryan Thurber. I am a colleague of Jennifer Evans, and I'm writing to follow up on communication Jen had previously coordinated with your office on behalf of our client Hopebridge because Jen is currently out of the country. As you'll recall, Hopebridge is a significant provider of autism therapy services to Colorado Medicaid beneficiaries, and they shared with the agency the difficulties they have faced furnishing services to Colorado children due to the low level of reimbursement provided by the program. The ability to serve Medicaid clients is extremely important to Hopebridge and its mission, but the status quo represents an untenable business environment. The parties previously discussed one potential opportunity to improve this situation for providers – a quality-based demonstration project. We understand from your message of June 8 that the Department is not currently able to commit to such a project for a single provider, even one with a significant Medicaid

population. We appreciate the Department's engagement on these issues. Unfortunately, the current reimbursement environment is not sustainable, and Hopebridge has begun background preparation for an orderly withdrawal from the Colorado market. Recent developments have led Hopebridge to believe that at least two additional key providers of Medicaid autism therapy services have either announced their intent to withdraw from Colorado or plan to in the near future. The access to care crisis for these services is only going to grow as any remaining providers feel the strain of trying to accommodate the beneficiaries displaced by these provider departures. Hopebridge is still interested in understanding whether adjustments can be made to the Department's current payment policies, whether through a state plan change, demonstration, or other efforts. Before taking any actions to withdraw that cannot be undone, Hopebridge asked that we reach out again to see if there is any renewed interest from the Department in continuing the conversation related to coverage and reimbursement for these services. While we recognize the initial July 1 deadline is unobtainable, if the Department believes rapid progress can be made on a solution Hopebridge is willing to delay its planned exit from Colorado for the sake of continued dialogue. If it would be helpful, the Hopebridge leadership team is ready and willing to coordinate another meeting with Department personnel at your convenience, either in person or remotely, to further this conversation. We would ask that you let us know this week whether the Department believes that meaningful progress on these issues can be made in the near future, and as noted above the Hopebridge team are happy to discuss what that might look like if it would be helpful. Thank you for the conversations thus far, and we look forward to continued progress on behalf of Colorado children. If it would be helpful to discuss by phone, please feel free to reach out.

Dr. J.J. Tomash
BehaviorSpan

The Silent Crisis of Autism Services in Colorado
Autism services in Colorado are in serious danger as providers flee the state.
By J.J. Tomash - June 30, 2023



Colorado is facing a crisis for Autism services. The average child is diagnosed with Autism in Colorado will have to wait more than 6 months before they can begin receiving services. Early intervention is critical to effective services- losing 6 months of early intervention can dramatically effect a child's outcome.
Why are waitlists for Autism services in Colorado 6 months long? The answer is that there are too few providers, and providers are either leaving the state or going bankrupt. The billing rates that providers receive for providing services for Autism and other developmental delays are practically the same they were 5 years ago, while the cost of doing business has gone up nearly 30%. This has made Autism services in Colorado an unsustainable business prospect for many, and they are Fleeing.

Waitlists to get Autism Services in Colorado
Applied Behavior Analysis is generally accepted as the "gold standard" for services for ASD and other developmental disabilities. It is the most widely accepted therapy, and has the most evidence-based platform for effective results. Autism services are critically time sensitive, and the effectiveness is at its highest the sooner a child can get services. If a child starts comprehensive therapy at 4 because they had to wait for services, it will impact their entire life.
Independent surveys conducted among companies that provide ABA services in Colorado in November of 2022 and again in June of 2023 found that on average new clients had to wait 6 months to enter their program.
The average family whose child receives an Autism diagnosis will have to wait half a year before a provider can begin services with them. This is after they have waited to get the initial diagnosis, which can easily take 6 months to one year (Per Children's Hospital).
The surveys also showed that these waitlists are getting longer, rather than shorter. In the last 8 months, the waitlists have grown by 14%, or 5 children. Please note, these data do not reflect the recent incidents in June, 2023 (see below).

	November 2022	June 2023
Average Wait	6 months	6.8 months
Maximum Wait	12 months	30 months
Waitlisted Clients	23.4	28.5

Table 1: Survey of Colorado ABA providers in November, 2022 (N = 23 providers) and June, 2023 (N = 17).

Families seeking services for Autism are in a difficult position in Colorado, and it is getting worse.

Autism Service Providers Leaving Colorado

This crisis in Colorado getting dramatically worse. Companies are leaving Colorado, going out of business, and cutting ABA services because they are unable to make a profit or break even.

In the last few years, at least 8 companies providing ABA services to children and

adults with Autism and Developmental Disabilities have either left the state of Colorado or have dramatically cut their ABA services because of difficulty breaking even. These 8 companies comprise at least 11 centers serving children with Autism. It is estimated that this will impact services to between 400 and 900 individuals with Autism and other Developmental Disabilities in Colorado. In addition to the above, other companies have significantly cut their ABA services offered to pivot in other directions that have better return.

If the above aren't worrying enough, the cuts to services seem to be accelerating. In the last few months:

- As reported in the news on June 21, 2023, Autism Support Services LLC will be leaving Colorado, and laying off 239 employees in the Autism services industry across three centers in Colorado.
- Additionally, as reported widely on June 12, 2023, the Center for Autism and Related Disorders (CARD) has recently filed for bankruptcy. They have 9 centers in Colorado.
- On March 24th, 2023, the Colorado Department of Health Care Policy and Financing (HCPF) had a public meeting to review Medicaid provider rates (More information available here). During this meeting (recording available), several providers expressed concerns with their ability to continue to provide serves in Colorado. One nation-wide ABA provider with 8 centers in Colorado stated that they have not been able to make a profit in Colorado and consequently they are engaged in internal discussions on whether to pull their services from the state entirely.

The effect of these latest events has not been felt yet on the waitlist numbers, but will be substantial.

Medicaid Rates for ABA Autism Services
Rates in Colorado for ABA Autism services have remained largely the same for the last 5 years.

		% Increase since 2018	
	Inflation	Staff Pay	Medicaid Rate
Behavior Technician	21%	26.2%	7.0%
BCBA	21%	10.7%	7.1%

Table 2: Percent increase in labor costs and Medicaid Reimbursement between April 2018 and June 2023.

The cost of doing business for providers has gone up nearly 30% in the last 5 years, while the amount they are reimbursed by Medicaid has gone up only 7%. This has driven providers to cut services, leave the state for other states with better profit margins, or go out of business. Among the providers I know, many are worried they will not survive the year.

Other States
Colorado is not the only state facing a critical shortage of ABA Autism therapy providers. According to Autism New Jersey, New Jersey faced a similar situation to ours, and responded by increasing their rate earlier this year from $44.80 to $60 per hour:

1. Families were not able to get ABA services, and expressed a great deal of frustration (they had waitlists seemingly equivalent to Colorado).
2. Upon looking into why ABA services weren't available,
they discovered that the low RBT rate meant that providers were losing staff because they couldn't afford to pay them more.
3. To solve the problem, they gave providers a 36% rate increase, which has been very favorably looked upon and has made a massive impact in the availability of services.

Key points:
Colorado is facing a silent crisis that very few people, outside of the Autism community, are aware of. It is generally understood that Early diagnosis and services for Autism is a critical component to therapy. Colorado has 6 month long waitlists to receive ABA Autism services. These 6 months are usually following waiting 6-12

months to receive the initial diagnosis. Families are left waiting for at least 6-12 critical months before they can get the help they need. These waitlists are only growing. Providers that are eager to provide services in Colorado are leaving and cutting services, citing an inability to break even with the current Medicaid rates. These rates have remained stable over the last 4 years, while the salaries that need to be paid to ABA therapists has grown over 26%.

It is difficult to adequately depict the difference that waiting 6 months for services has on a child's outcome. It effects their ability to learn in school, which impacts their ability to advance in school. Eventually the cumulative result of those lost 6 months can mean massive differences in their ability to function and live independently. The opportunity cost is only visible to the families and the providers that work with these individuals. The opportunity cost not only effects the individual, but their family, their community, and the state as a whole. Perhaps there is no way to calculate the eventual cost of the growing crisis in Colorado, but being aware of it is a great start.
I implore HCPF and the Joint Budget Committee to recognize the impact the shortage of providers will have on families, and to send a message that Colorado sets the standard for providing exceptional services to its citizens with Autism- and we start with those that are the most vulnerable.

Andy Li
Mindcolor Autism

https://bhbusiness.com/2023/07/12/hopebridge-ceo-low-medicaid-rates-inflation-costs-give-aba-provider-no-other-choice-but-to-pull-out-of-colorado/

Hopebridge's CEO, David McIntosh, attributes the cuts to Colorado's insufficient Medicaid reimbursement, intractable state officials and significant increases to state operating costs.
"Colorado Medicaid has left us no other choice than to withdraw from ABA services," McIntosh said.

Dr. J.J. Tomash
BehaviorSpan

The below news article came out today, in which they talk about a large provider announcing today that they are leaving Colorado because they cannot stay with the current rates.

https://bhbusiness.com/2023/07/12/hopebridge-ceo-low-medicaid-rates-inflation-costs-give-aba-provider-no-other-choice-but-to-pull-out-of-colorado/

I figured this is very pertinent to the committee and their review, and wanted to pass it along.

[REDACTED due to HIPAA]

I would like to voice my concerns about the unsustainable reimbursement rates for ABA therapy through Colorado Medicaid. As a parent of a child on the spectrum who receives Medicaid services, and an ABA professional myself, I am deeply concerned with the low Medicaid reimbursement rates for ABA therapy. It has started to affect companies ability to provide services and forced several to close. ABA therapy has been life changing for my son and our family, and we would be devastated if our company had to close, not to mention that it would affect my employment should the company I work for be affected. With the rising cost of living in Colorado, it is unsustainable and not right for ABA reimbursement to continue to be so low. So many families of kids on the spectrum rely on ABA services funded by Medicaid. I plan to attend the rare review meeting this Friday, but wanted to add my voice beforehand.

Ken Winn, M.S., BCBA, LBA
he/his/him
President, Colorado Association for Behavior Analysis

Please see attached. We will be providing input tomorrow for the meeting tomorrow where we will be discussing rates for Pediatric Behavioral Therapy and the “holistic” approach with COABA.

We are concerned that the data presented is grossly inaccurate. Providers are leaving the state in droves, mainly because of the rates for PBT services. See below.

https://bhbusiness.com/2023/07/12/hopebridge-ceo-low-medicaid-rates-inflation-costs-give-aba-provider-no-other-choice-but-to-pull-out-of-colorado/?fbclid=IwAR3LwsiK1xCgdhkppDRRAUirh9MlRDlJhJtqqXHikIJlEmiW1zD2Fo2M3sg

It is not an overstatement to say this is a crisis in Colorado. Many vulnerable Coloradoans with Autism Spectrum Disorder, and related conditions, are less likely to receive this important service and those on waitlists will have to wait even longer for the few providers still providing services. A rate increase is needed IMMEDIATELY to prevent even more providers from leaving and preventing clients from getting the services they so desperately need.

I will be speaking on behalf of COABA to address the need for an emergency increase in rates as well as the inaccuracy of the data presented. We at COABA appreciate the ongoing collaboration with your committee and look forward to the opportunity to provide input at the meeting tomorrow.

Would there be an opportunity to have a meeting with the committee members and the COABA Board of Directors?

Barb Kirkmeyer

Dear Chair Kretsch, members of the Medicaid Provider Rate Advisory Review Committee (MPPRAC) and staff, It is my understanding that you will be having your quarterly meeting, tomorrow, July 14. Based on previous presentations, I see that you all are comparing Pediatric Behavioral Therapy (PBT) rates to 7 other states: Louisiana, Nevada, North Carolina, Utah, Washington, Texas and Florida. I am requesting that you also consider including comparisons to Tri-Care rates, as well as looking at states like California and Nevada. I believe this will give us a more comprehensive understanding of where Colorado lands on Rates.

Jennifer Paz Ryan, M.Ed, Psy.D. (she/her/hers/ella)
Bilingual Co-Founder of Elevated Insights Assessment, LLC
www.elevatedinsights.org

I have a private practice in Denver that provides neuropsychological testing services to children ages 18months through adulthood. We currently accept Medical Medicaid with 80% of our practice serving individuals on Medicaid. We also provide multilingual (English/Spanish) neuropsychological testing.

We hope you are aware that there is currently an Autism Crisis in Colorado. Please see the screen shot attached. A few other articles include: Hopebridge CEO: Low Medicaid Rates, Inflation Costs give ABA Provider 'No Other Choice' But to Pull Out of Colorado - Behavioral Health Business (bhbusiness.com)

[Updated] Invo Healthcare Exiting Home- and Center-Based ABA, Transitioning Business Assets to Other Operators - Behavioral Health Business (bhbusiness.com) Our practice is known for ASD testing across ALL counties in Colorado. We are unable to hire licensed psychologists who have niche training in neuropsychological assessment due to the significantly low rates that are paid out by Medicaid. The cost of living in Colorado is extreme and has not been accounted for in the current rate and MUST be considered for the upcoming changes which will remain steady for the following 3 years at least!

Additionally, we provide Spanish speaking and bilingual neuropsychological assessment services. Less than 5% of psychologist's in the US identify themselves as Hispanic or Latinx and speak Spanish. Even less specialize in testing. Current research does not support the use of an interpreter for testing when a native or bilingual professional is available. Utilizing an interpreter also lends itself to lead to invalid results and misdiagnoses. Interpretation services currently run $3.99-4.99 per minute. It is imperative for equity that a modifier be created for services that are directly provided in another language at an additional $75-100 per unit for equity and best practice.

Jennifer Paz Ryan, M.Ed, Psy.D. (she/her/hers/ella)
Bilingual Co-Founder of Elevated Insights Assessment, LLC
www.elevatedinsights.org

Can you please forward this to the group as well? While advocating for higher rates, our current rates were reduced without any notice. This is absolutely ridiculous and not mentioned in the call we had on Friday. Medicaid rates specifically related to psychological/neuropsychological testing were significantly reduced as of July 1, 2023. We NEVER received any notification and only realized it when we went to pay our providers and were negative. Here is a table of the rate changes:

Previous New Change
90791 $156.98 $161.69 + 2.9%
96136 $ 64.82 $ 43.82 - 32.4%
96137 $ 47.44 $ 40.49 - 14.6%
96132 $126.03 $105.50 -16.3%
96133 $ 99.82 $ 80.45 -19.4%

Please note that the only rate that increased is a code that can be used by ANY individual and does NOT require niche or specialty training. This means that HCPF and Medicaid are valuing the generalist while devaluing the specialist. There is NO way we can pay our licensed psychologists that specialize in neuropsychological assessment salaries and benefits with these paltry rates. As of this today, we have 7 private practices in Colorado that accept Medicaid and provide these niche diagnostic testing services, that have stated they will NO LONGER be accepting Medicaid clients due to the rates and due to the move to the RAE's. It has been made clear by Children's hospital and community mental health centers that they alone CANNOT keep up with the need for testing and rely on us to provide these services. There is a current autism crisis in Colorado and this is going to be catastrophic.

What is going to happen when the few providers outside of community mental health centers and Children's (who already have waitlists that exceed a year) pull out due to these disparities and inequity? The implications of these changes will have a devastating impact on our state and ALL individuals who have ASD, ID, DD. Moving ASD testing to the RAE's which would require preauthorization (and has a current 99.9% denial rate) along with a tendency to seek recoupment is a loss of basic rights for their members. As a privileged Latina in Colorado, if my insurance denies my preauthorization, I have the luxury and the right to pay out of pocket for testing services. If I was covered by Medicaid, my human right away to seek a different opinion is revoked as it is considered insurance FRAUD to pay out of pocket for these services. Our brown and black communities are going to be further marginalized and these changes will ultimately cost the state billions of $$$. This is a parents right issue and human rights issue. Please let me know what other information is needed for you to lend your voice and power to advocate for us and all Medicaid members. I hope you hear my passion and my dedication to serving my community.

[REDACTED due to HIPAA]

Thank you for your time today,

The amount of centers that have already closed and the amount of children that will be out of necessary services is totally unacceptable, this issue is urgent and parents and providers need

answers and solutions immediately. Any kind of lapse in ABA therapy for a child diagnosed with Autism will be detrimental to their development, their health, and their overall wellbeing. This issue will impact the future of so many children on the spectrum, something needs to be done. Before multiple closures of centers there were already issues with long waitlists. I have two children on the spectrum, my son has shown an immense amount of growth from one year of ABA. However my daughter was diagnosed at 18 months old, and now after 8 months of waiting patiently she has still not received 1 day of ABA services. Early intervention is extremely important for a child's development. It is the only way to set them up for a successful future and to give them the tools they need to do well in school and be healthy productive adults in the future. But with this crisis in CO going on we are making it impossible for parents to seek services while their children are at this crucial young age. From a concerned parent, I am extremely disappointed and let down that this issue was not solved before all of these centers had to close.Thank you

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Dr. J.J. Tomash
BehaviorSpan

Insofar as I am able without overstep, I want to thank you on behalf of Colorado providers for your service today helping to end the Medicaid Provider crisis. Your bold recommendation to increase our rates sends a message that there is a way to save Autism services in Colorado and brings hope to many families that are suffering and providers that worry they will lose their ability to help. I understand that you are unable to make an emergency rate adjustment, but I hope that your recommendation that one is needed inspires action in HCPF and the JBC to take up the mantle and bring relief. I have no doubt that providers who were before considering announcing their closure will see today's action and decide to hold on a little longer. An immediate emergency supplemental action by HCPF could instantly stave the loss of providers, and you have provided them the necessary recommendation to do so. I agree fully with your recommendation to match the benchmark states at 100%, adjusting for the cost of living. I also agree with the recommendation to look into funding services that aren't currently reimbursed in Colorado, but are in the benchmark states. Upon reviewing the benchmark states and cost of living math, I did come calculation errors, which I think should be addressed before the recommendation is acted upon. I will include this analysis, along with calculation of the rates, in an addendum for your review. Again, thank you for your service today. You have played an important part in securing a brighter future for families in Colorado.

Addendum:

In the presentation today, the following summary was presented to compare Colorado to benchmark states:

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Living cost adjustment															
			Other States Rates												
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other States Average	Percent
97151	BHV ID ASSMT BY PHYS/QHP	$ 9.80	$ 18.62	$ 20.71	$ 28.00	$ 27.64	$ 60.12	$ 17.31	$ 16.94	$ 26.57	$ 35.73	$ 14.48	$ 26.61	37%
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 13.64	$ 11.92	$ 11.03	$ 15.70	$ 18.82	$ 40.08	$ 22.53	$ 11.95	$ 12.10	$ 17.66	$ 9.56	$ 17.13	80%
97154	GRP ADAPT BHV TX BY TECH	$ 6.83	$ 6.43	$ 9.37	$ 6.28	$ 10.28	$ 40.08	$ 5.66	$ 10.39	$ 2.02		$ 8.15	$ 10.96	62%
97155	ADAPT BEHAVIOR TX PHYS/QHP	$ 21.28	$ 16.76	$ 20.71	$ 28.00	$ 29.14	$ 40.08	$ 22.53	$ 26.06	$ 20.39	$ 35.73	$ 10.86	$ 25.03	85%
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 10.64	$ 8.39		$ 7.64		$ 60.12	$ 14.10		$ 3.40		$ 8.15	$ 16.97	63%

Figure 1: MPRRAC Living Cost adjustment Rates across comparison states.

The amounts for each state are adjusted by multiplying them by some cost of living multiplier to account for different costs of living in the different states. However, a few problems become apparent if one looks at the same chart but with the actual Medicaid rates from each state:

ACTUAL RATES			Other State Rates											
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other State Average	Percent
97151	BHV ID ASSMT BY PHYS/QHP	$ 10.34	$ 19.05	$ 30.73	$ 33.46	$ 26.56	$ 54.17	$ 17.54	$ 13.00	$ 24.71	$ 36.27	$ 16.67	$ 27.22	38%
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 14.39	$ 12.19	$ 16.37	$ 16.73	$ 18.09	$ 36.11	$ 30.10	$ 13.75	$ 11.25	$ 17.92	$ 11.00	$ 18.35	78%
97154	GRP ADAPT BHV TX BY TECH	$ 7.21	$ 7.58	$ 13.91	$ 6.08	$ 9.88	$ 36.11	$ 7.14	$ 10.40	$ 1.88		$ 11.00	$ 11.55	62%
97155	ADAPT BEHAVIOR TX BY PHS/QHP	$ 22.45	$ 19.05	$ 30.73	$ 33.46	$ 28.00	$ 36.11	$ 30.10	$ 13.75	$ 21.06	$ 36.27	$ 12.50	$ 26.10	86%
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 11.22	$ 9.58		$ 9.13		$ 54.17	$ 14.28		$ 2.81		$ 11.00	$ 16.83	67%

Figure 2: Actual Rates across comparison states.

First, the multiplier does not seem to be equally applied for each code across the state, whereas the cost of living would remain within the state. Second, and more importantly, the numbers in the percent columns have very little change between the real rates and the adjusted cost of living rates (Percent Column in Figure 1 and 2). The reason for this is that the multiplier was not just applied for comparison states, but was also applied to the Colorado rates as well- negating any effect it had to adjust the rate for cost of living. It is hard to correct for these errors without knowing the source of the cost of living multiplier. We have run our own adjustment, using a universally accepted cost of living metric across states. 1

1 https://wisevoter.com/state-rankings/livable-wage-by-state/#colorado

Adjusted for Cost of Living (by State)			Corrected for Cost of Living Statewide										
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	TX	UT	Other State Average	Percent	100% of benchmark (new rate)
97151	BHV ID ASSMT BY PHYS/QHP	$ 10.34	$ 17.16	$ 27.04	$ 32.46	$ 29.75	$ 62.30	$ 20.70	$ 28.91	$ 40.99	$ 32.41	32%	$17.38
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 14.39	$ 13.53	$ 14.41	$ 16.23	$ 20.26	$ 41.53	$ 35.52	$ 13.16	$ 20.25	$ 21.86	66%	$19.31
97154	GRP ADAPT BHV TX BY TECH	$ 7.21	$ 19.05	$ 23.80	$ 31.48	$ 33.32	$ 71.64	$ 24.42	$ 2.20		$ 29.42	25%	$12.65
97155	ADAPT BEHAVIOR TX BY PHS/QHP	$ 22.45	$ 15.02	$ 12.68	$ 15.74	$ 22.69	$ 47.76	$ 41.91	$ 24.64	$ 40.99	$ 27.68	81%	$26.69
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 11.22	$ 9.34		$ 5.72		$ 47.76	$ 9.94	$ 3.29		$ 15.21	74%	$14.16

Figure 3: Comparison States with Adjustment for Cost of Living.

As can be seen, adjusting for differences in the cost of living by state changes the percent of each benchmark by a small amount, giving a more accurate comparison. One further consideration worth noting is that the comparison states of Oregon and Washington are currently experiencing similar crises to Colorado, and are also undergoing potential Medicaid rate adjustments to keep their services intact. For this reason, using their current low rates

might not be fair for the comparison. Comparing Colorado's rates to other states that share the same crisis does not lend itself to a solution. Below is a table showing the true Benchmark comparison with those states removed.

Adjusted for Cost of Living (by State)			Corrected for Cost of Living Statewide										
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	TX	UT	Other State Average	Percent	100% of benchmark (new rate)
97151	BHV ID ASSMT BY PHYS/QHP	$ 10.34	$ 17.16	$ 27.04	$ 32.46	$ 29.75	$ 62.30	$ 20.70	$ 28.91	$ 40.99	$ 32.41	32%	$17.38
97153	ADAPTIVE BEHAVIOR TX BY TECH	$ 14.39	$ 13.53	$ 14.41	$ 16.23	$ 20.26	$ 41.53	$ 35.52	$ 13.16	$ 20.25	$ 21.86	66%	$19.31
97154	GRP ADAPT BHV TX BY TECH	$ 7.21	$ 19.05	$ 23.80	$ 31.48	$ 33.32	$ 71.64	$ 24.42	$ 2.20		$ 29.42	25%	$12.65
97155	ADAPT BEHAVIOR TX BY PHS/QHP	$ 22.45	$ 15.02	$ 12.68	$ 15.74	$ 22.69	$ 47.76	$ 41.91	$ 24.64	$ 40.99	$ 27.68	81%	$26.69
97158	GRP ADAPT BHV TX BY PHY/QHP	$ 11.22	$ 9.34		$ 5.72		$ 47.76	$ 9.94	$ 3.29		$ 15.21	74%	$14.16

Figure 4: Comparison States with Adjustment for Cost of Living.

Please let me know if you have any questions about the above analysis or the information sources used.

Ian Goldstein
Soar Autism Center

Thank you to the committee for hearing the provider feedback on the rate benchmarking analysis. Though I still think the rate benchmark analysis underestimates the gap between Colorado and other states, I do believe these analyses and recommendations are much more accurate than the initial analyses put forth this spring/summer. The rate updates would be a meaningful change that would help with the dramatic workforce challenges our industry is facing, were the committee's recommendations to be put in place. I do have concerns around the HCPF commentary at the JBC meeting in September where it feels like they are less aligned on a rate increase, and I'd like to see the committee's recommendations listened to. I would hate to go through this process with MPRRAC only for the recommendation to change at the last minute by the governor's office, after being told repeatedly to follow this process. Relatedly, it's a little unclear why there isn't more support from the governor's office for this work given the access to care and workforce dynamics we are experiencing. We are appreciative of the 2-3% annual increases the Colorado budget has added in the last two years; unfortunately our costs have gone up 20-25% over the same time frame and so the operating pressure we feel is real and needs to be corrected to have a sustainable operating environment to serve children and families.

David Briedis
Behavioral Innovations

I'd like to better understand process and timelines for review and implementation of MPRRAC and HCPF recommendations

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Rebecca Urbano Powell
Seven Dimensions Behavioral Health

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I am grateful to the committee for a thorough report and recommendations. I am concerned about the statement that PBT is at 78% of the benchmark which is not accurate when you apply to codes in a typical use case format. Under a typical use case format using the units per hour for an average patient, we are 69% of the benchmark. I am also concerned over use of codes 0362T and 0373T as these are not permanent codes yet which opens them up to interpretation by HCPFs third party PAR review company who is already making many inaccurate interpretations of the current medical necessity definition for CO. I would prefer to wait on adopting those codes until the extreme issues presented by the review process are resolved.

J.J. Tomash
BehaviorSpan

The two most important PBT codes for my company are 97153 and 97155. I want to be clear that these are the two codes that make up the vast majority of our billing.

JJ
Play To Learn Therapies

Benchmark is still low

Emma Hudson
Emma Hudson Consulting LLC

We were reviewing the MPRRAC Draft report and have some questions about what's written related to PBT services, but the primary concern is rooted in the math used for integrating cost of living across various states which is how the 100% benchmark formula is determined.

Our analysis suggests there may be a mathematical error in the calculation presented. The simplest way to explain the error as we see it is the cost of living equation that was created to factor in cost of living to the comparison states was *also* added to Colorado. We believe this was done in error since it essentially eliminates the impact of cost of living when done this way. It seems logical that Colorado should be left as the baseline measure and the formula for cost of living would only be applied to the comparison states, but maybe we're missing something?

Would it be possible to have a short discussion with someone about this asap (whoever is doing the calculations maybe?) and/or receive some explanation for this approach if it's intentional?

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We'd be very appreciative! As discussed previously, I know we're all hoping to be operating from the same baseline understanding of where we are now, even if there isn't total agreement on where we should end up.

Aidan Wiemer

Analysis of Proposed Rate Increase for Colorado ABA Behavioral Health Providers

The following is a report commissioned by the Colorado Association of Behavioral Analysis to review the findings of the Medicaid Provider Rate Review Advisory Committee's analysis of proposed rate adjustments for ABA behavioral health providers.

Background & Qualifications

I graduated from the University of Colorado, Boulder Magna cum Laude in Economics. During my time at the University of Colorado, I submitted reports to legislators on the economic impacts of bills under consideration by the General Assembly; namely: HB22-1260, SB22-090, SB22-186, and SB22-198. I testified before the House Education Committee on the economic ramifications of HB22-160 and before the Senate Health & Human Services Committee on SB22- 186.

I was contacted by the Colorado Association for Behavioral Analysis (COABA) and asked to review the analysis of the Colorado Medicaid Provider Rate Review Advisory Committee (MPRAC) in regard to proposed rate adjustments for ABA behavioral health providers. The following is my analysis. I am not being paid or otherwise compensated for my analysis.

Methodology

I conducted my analysis using the same methodology as the MPRAC analysis. Medicaid billing rates for ABA codes 97151, 97153, 97154, 97151, and 97158 were compiled for Colorado and ten comparison states: Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington. All comparison states use the same fee-for-service model that Colorado uses. The ten comparison states were selected by MPRAC so that seven had higher rates and three had lower rates, compared to Colorado. The average billing rate of the ten comparison states is used to create a national baseline, against which the Colorado billing rates are then compared to determine the shortfall in the current billing rate.

All billing rates are adjusted for the cost-of-living in each state. This is done to account for the Penn effect, which is the tendency for prices to be higher in high-income areas and lower in low-income areas. Therefore, it costs more to live in high-income areas as prices for goods and services are higher compared to lower-income areas. For example, a healthcare provider in California would have to charge more for their services compared to a provider in Mississippi to achieve the same standard of living, because it costs more to live in California. Given this divergence, it is necessary to standardize prices across all states in the analysis. This is accomplished by using a cost-of-living adjustment (COLA). To calculate a cost-of-living adjustment for US states, each state is assigned an index score to measure their cost-of-living, relative to the United States which is assigned a score of 100. For example, if a state had an index score of 200 it would be twice as expensive as the nation at large.

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There are a number of different indexes that one can use, and each index varies slightly. However, most calculate their index scores using consumer price index (CPI) data from each state. The cost-of-living adjustment (COLA) is calculated using the following equation:

MPRAC Analysis

In my review of the MPRAC analysis I discovered an issue with their cost-of-living adjustment. Reverse engineering the base rates from the adjusted rates presented in MPRAC's July 24, 2023 presentation[1] I calculated the cost-of-living adjustments they used for each state, summarized below in table 1.

Table 1:
MPRAC Cost-of-Living Adjustment Index

State	Index Score
Colorado	105.5
Florida	102.3
Massachusetts	148.4
Maryland	119.5
North Carolina	96.1
Nebraska	90.1
Nevada	101.3
Oregon	115.1
Texas	93.0
Utah	101.5
Washington	115.1

[1] Colorado Medicaid Provider Rate Review Advisory Committee. (2023). *Medicaid Provider Rate Review Public Meetings*.

The issue with the cost-of-living index used by MPRAC is its source. The index scores in Table 1 correspond exactly to an online index from worldpopulationreview.com.[2] However, this website does not list any methodology for how it calculated its cost-of-living index. The site only links to a cost-of-living index from the Missouri Economic Research and Information Center,[3] which provides an entirely different index than what is provided by worldpopulationreview.com.

Therefore, I have limited confidence in the veracity of worldpopulationreview.com's data. As I will detail below, there are other cost-of-living indexes from more reliable sources that I use in my analysis.

Wiemer Analysis

For this report, I redid the analysis by MPRAC using the regional price parities from the US Department of Commerce's Bureau of Economic Analysis (BEA).[4] The BEA calculates its cost-of-living index from the Bureau of Labor Statistics (BLS) Consumer Price Index. Data from the BLS is considered to be the gold standard when conducting economic research due to its reliability, rigorous data

collection, and comprehensiveness. Using the BLS data, the BEA calculates price inflators and deflators that equalize prices across states. These are referred to as regional price parities.

It bears note that the most recent update of the BEA regional price parities was for 2021. Due to the BEA's due diligence in data collection and analysis, there is a lag before they release yearly regional price parity data. The next update, for 2022 regional price parity, will be released at the end of this year. Regardless, the BEA data is still considered to be reliable and the premier source for cost-of-living index data.

My analysis uses the base state billing rates compiled by MPRAC for their analysis. In Table 2, I summarize the base rates that I reverse engineered from the MPRAC analysis.

Table 2: Reported by MPRRAC 7/24/23 (Calculated Base Rates)			Other State Rates											
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other State Average	CO Rate Percent of Benchmark
97151	BHV ID ASSMT BY PHYS/QHP	$10.34	$19.05	$30.73	$33.46	$26.56	$54.17	$17.54	$19.50	$24.71	$36.27	$16.67	$27.86	37%
97153	ADAPTIVE BEHAVIOR TX BY TECH	$14.39	$12.19	$16.37	$18.76	$18.09	$36.11	$22.82	$13.75	$11.25	$17.92	$11.00	$17.83	81%
97154	GRP ADAPT BHV TX BY TECH	$7.21	$6.58	$13.91	$7.50	$9.88	$36.11	$5.73	$11.96	$1.88		$9.38	$11.44	63%
97155	ADAPT BEHAVIOR TX BY PHS/QHP	$22.45	$17.15	$30.73	$33.46	$28.00	$36.11	$22.82	$30.00	$18.96	$36.27	$12.50	$26.60	84%
97158	GRP ADAPT BHV TX BY PHY/QHP	$11.23	$8.58		$9.13		$54.17	$14.28		$3.16		$9.38	$16.45	68%

[2] *Cost of Living Index by State [Updated June 2023].* (2023, June). Retrieved from WorldPopulationReview.com

[3] *Cost of Living Data Series*. (2023, April). Retrieved from Missouri Economic Research and Information Center

[4] Figueroa, E., & O'Connell, C. (2022). *Real Personal Consumption Expenditures by State and Real Personal Income by State and Metropolitan Area, 2021.*

Using the calculated base rates in Table 2, I calculated the cost-of-living adjustment using the regional price parities from the BEA. I used the equation from the methodology section above. My results are detailed in Table 3.

Colorado falls short of the national benchmark for all five procedures' billing rates. This is true for both my analysis and the analysis completed by MPRAC. Table 4 shows the billing rate shortfall in Colorado for both analyses.

Table 4: BEA & MPRAC Adjusted Shortfall			
Procedure Code	Procedure Description	Percent of Benchmark (BEA Adj.)	Percent of Benchmark (MPRAC Adj.)
97151	BHV ID ASSMT BY PHYS/QHP	36%	37%
97153	ADAPTIVE BEHAVIOR TX BY TECH	77%	80%
97154	GRP ADAPT BHV TX BY TECH	60%	62%
97155	ADAPT BEHAVIOR TX BY PHS/QHP	81%	85%
97158	GRP ADAPT BHV TX BY PHY/QHP	64%	63%

Conclusion

Colorado Behavioral Health Specialists are currently underpaid for ABA behavioral therapy services compared to the national average. As such, I recommend that the Joint Budget Committee approve a rate increase for Colorado providers. My exact recommendation for each billing code is below in Table 5 in the green column. The MPRAC recommendation is listed in the grey column.

Table 5: Recommended Rate Increase

Procedure Code	Procedure Description	CO HealthFirst Current Rate	Recommended CO HealthFirst Rate	MPRAC Proposed CO HealthFirst Rate
97151	BHV ID ASSMT BY PHYS/QHP	$10.34	$17.00	$16.87
97153	ADAPTIVE BEHAVIOR TX BY TECH	$14.39	$17.70	$17.33
97154	GRP ADAPT BHV TX BY TECH	$7.21	$10.07	$9.92
97155	ADAPT BEHAVIOR TX BY PHS/QHP	$22.45	$26.68	$25.81
97158	GRP ADAPT BHV TX BY PHY/QHP	$11.23	$15.31	$15.41

My findings differ slightly from those of the MPRAC analysis. This is due to their use of a different cost-of-living adjustment index. The use of the more reliable BEA regional price parity index showed that Colorado needs a slightly larger rate increase, than that proposed by MPRAC, to achieve price parity with the national average. Regardless of which analysis you use, it is my recommendation that you increase billing rates for ABA therapy providers in Colorado to fairly compensate them for their services.

References

Colorado Medicaid Provider Rate Review Advisory Committee. (2023). *Medicaid Provider Rate Review Public Meetings*. Retrieved from Colorado Department of Health Care Policy & Financing: https://hcpf.colorado.gov/rate-review-public-meetings

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Figueroa, E., & O'Connell, C. (2022). *Real Personal Consumption Expenditures by State and Real Personal Income by State and Metropolitan Area, 2021*. Washington, D.C.: Department of Commerce, Bureau of Economic Analysis.

Maternity Services

Jeanne Bair

August 2, 2023
Dear Ms. LaPlante and Members of the HCPF Rate Review Advisory Committee:
As leaders of the Colorado Affiliate of the American College of Nurse-Midwives and on behalf of Certified NurseMidwives in Colorado, we would like to recognize the importance of the Health Care Policy and Financing Medicaid Provider Rate Review Advisory Committee's recommendation to increase the rates of payments from Health First Colorado for maternity services in Colorado. Improving reimbursement for maternity care will allow more Colorado providers, in particular Certified Nurse-Midwives, to increase services to Health First Colorado members throughout the state and ultimately improve equity and health outcomes for Coloradans.

Medicaid policies are a key factor in access to maternity care- and midwifery care- for Colorado's most vulnerable communities. Research studies have repeatedly demonstrated that low Medicaid reimbursement limits the ability of providers, including hospital-based and community-based midwifery group practices, solo providers, and birth centers, to sustain their practice models: reimbursement is often too low to cover the actual cost of care. 1, 2 Most midwifery practice groups provide almost exclusively maternity care services and little or no surgical services or primary care services like Ob/Gyn or Family Medicine physicians do. For physicians, these services can offset losses from low Medicaid reimbursement. However, in the maternity care-based financial models of midwifery practice groups, low maternity care reimbursement, especially for uncomplicated vaginal births, makes midwifery practices susceptible to closure, 3, 4 high turnover of midwives due to low pay, and creates stagnation in forming new midwifery practice sites across the state. 1, 5 This phenomenon is more acute in rural, low birth volume communities. 6-8

Additionally, many midwifery practice groups in Colorado provide a larger- than- average proportion of care to Medicaid beneficiaries than physicians (i.e., they do not 'cap' the number of Medicaid beneficiaries who can access their services). And importantly, midwives in Colorado provide high-quality care for childbearing individuals with public insurance; this has been demonstrated over several decades in research, and most recently in HCPF's report on maternity care outcomes for Health First Colorado members. 5, 9-12 Together, these facts highlight the importance of midwifery care as essential to providing access to high-quality maternity care across Colorado. As highlighted in two recent national reports, we encourage HCPF and other leaders in the state to continue to invest in policies that support increased access to midwifery care as a primary intervention in improving the health of Colorado's childbearing families. 13, 14

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In 2022, a March of Dimes report identified 38.1% of Colorado counties as maternal health care deserts. 15 In a country with the highest maternal mortality rate of any developed country-higher than previous decades, we must commit to developing strategies that will increase access to services, support the highest standards in care, and promote integration of multidisciplinary services across the entire perinatal period. As the professional association representing Certified Nurse-Midwives and Certified Midwives in Colorado, we look forward to engaging with HCPF, other state agencies, lawmakers, and our communities in developing these strategies. We thank the advisory committee for an important step toward that goal.

Respectfully,
Executive Board, Colorado Affiliate of the American College of Nurse-Midwives
Jeanne P. Bair, DNP, CNM, FACNM
Denise C. Smith, PhD, CNM, FACNM
Jolene Hamann, CNM, WHNP-BC
Terra Rhoades, CNM
Carolyn Bottone-Post, DNP, CNM, CNE, FACNM
Kala Kluender, CNM

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6. March of Dimes https://www.marchofdimes.org/where-you-livematters-maternity-care-deserts-and-crisis-access-and-equity

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Denise Smith
American College of Nurse-Midwives

The professional association representing Nurse-Midwives in Colorado is in support of the advisory panel's recommendation to increase to 100% of the benchmark.

Abortion Services

Jack Teter
Planned Parenthood of the Rocky Mountains

Rates are too low to provide abortion services, especially compared to Oregon and Illinois. Only covers 10 – 20 abortions annually. Abortion care was only reimbursable when provided in hospital settings (though only one hospital statewide provides abortion care, and 99%+ of abortions happen in outpatient offices). This is, in many ways, actually a new benefit. PPRM provides unreimbursed abortion care for several thousand Colorado Medicaid patients annually, and I would be happy to provide any additional data that might be helpful to this group. The out-of-state patient increase is relevant because it increases the wait time for Colorado Medicaid patients by several weeks -- and thus the cost for care increases. Colorado Medicaid will never cover out-of-state patients, but the burden on providers right now is extraordinary. $1,000 for 59840 and 59841, $800 for F0199. Abortion care is only a covered service for patients enrolled in Colorado Medicaid in cases of rape, incest, and direct life endangerment to the pregnant person. In addition, the state mandates that providers submit significant documentation to validate coverage in those instances. Abortion care is not covered in cases of health endangerment. Prior to the passage of SB21-142, abortion care in those limited circumstances was only covered by Medicaid if the care was provided in a hospital or ambulatory facility setting. Because most Colorado hospitals do not provide abortion care, the policy resulted in virtually no access to that covered care. As a result, sexual violence survivors in places like Cortez faced an eight-hour one way drive if they needed to access abortion care. According to CDPHE's statewide abortion data report, <1% of abortion care provided in the state occurred in a hospital setting -- fewer than 100 patients statewide annually. The data doesn't show what percent of those patients were enrolled in Medicaid but given the very limited instances in which abortion care is ever covered by Medicaid, I would estimate that Medicaid likely paid for no more than 10 abortion visits each year. 1 – Those numbers have now increased slightly, to include perhaps 30 patients annually. In 1983, Medicaid covered abortion care at a rate of $256 for approximately 1,700 patients. 2 - The public funding ban passed the following year, in 1984.3 - By 1990, the state spent less than $1,000 total annually providing abortion care for only three patients statewide.4 - Today, procedural abortion care is reimbursed by Colorado Medicaid at a rate of $190.11 for CPT 59840 and $245.99 for CPT 59841 – lower than the rates in 1985. Indeed, adjusting for inflation, the $256 rate of 1983 equates to $762 in today's dollars. In comparison, the current reimbursement rate for those two services in California and Oregon is over $1000.5 Medication abortion is reimbursed at a rate of $403.87.

CO Rate Setting:

Abortion services are generally billed under three CPT codes – S0199, Medication abortion (up to roughly 10 weeks six days, 59840, Induced Abortion, D&C (up to roughly 14 weeks) and 59841, Induced Abortion, D&E (from approximately 9 to 24 weeks). Because the two procedural codes represent a wide range in complexity of care, ideal reimbursement would

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allow for modifiers to indicate different rate tiers depending on gestational age. On the provider side, the cost to provide care increases exponentially as gestational age increases. Rate setting is complex, and the rate setting for abortion care is artificially depressed due to factors including abortion stigma and a lack of federal Medicaid coverage due to the Hyde Amendment. The federal Centers for Medicare & Medicaid Services (CMS) uses Resource-Based Value Scale (RBRVS) as a benchmarking method to associate cost with providing specific services. The basis of the RBRVS methodology is the relative value unit (RVU), based on complexity, time, required resources, and risk. Each CPT code's total RVU is segmented into three categories: work, practice and professional liability insurance (PLI). This allows health systems to drill-down possible expense to service misalignment. Like the relative value, health center expenses are divided into the same three categories: work, practice, and malpractice.

1. Work Expense is the total amount of salaries and benefits paid to providers
2. Practice Expenses are those costs that are associated with running operations, including:
    a. Salaries and benefits for ancillary staff (health center assistants, nurses)
    b. Training and staff licensure, dues, memberships, and site licensure
    c. Office & General Supplies
    d. Occupancy (rent, utilities, repair and maintenance, depreciation, casualty and liability insurance, and security)
    e. Minor equipment and computer costs, equipment repair and maintenance
    f. Telecommunications, bank service charges
3. Provider liability insurance

Suggested Rate:

The current Colorado rate for procedural abortion care in ambulatory centers more closely aligns with the cost of care at $602.85 for CPT 59840 and for CPT 59841. There is not a separate rate for S0199, medication abortion, in ambulatory surgical centers. While ideal rate setting would allow for modifier adjustment depending on gestational age, which impacts provider time, resources, increased medical decision-making and complexity, we suggest matching the provider rate to the ambulatory rate on an adjusted basis. $600 is a reasonable rate for care provided up to 11 weeks and 6 days after a patient's last menstrual period, though the cost to provide the care is closer to $1200. Prior to the US Supreme Court’s decision in Dobbs v. Jackson Women’s Health Organization, this rate would pertain to the vast majority of abortion care provided in the state.6 However, in the months since the decision, we have seen patient care pushed out by at least three weeks on average, including for in-state patients, due to the influx in out-of-state patient seeking care with Colorado providers, further increasing the cost of care. Other states have adjusted their reimbursement rates for abortion care since 2022 by differentiating between the rates for 59840 and 59841. Illinois, for example, now reimburses $660 for 59840 and $1,600 for 59841, while New Mexico reimburses $704.48 for 59840 and $1,142.66 for 58841. Given the actual cost to provide abortion care in 2023, 59840 should be covered at a rate of $1000, 59841 should be covered at $1,600, and S0199 should be reimbursed at a rate of $800. While the vast majority of abortion services for Medicaid patients in Colorado are covered with private philanthropic dollars, it remains important for Medicaid providers to be reimbursed for care at rates that both value patient need and fairly reflect the clinician’s efforts to serve patients. There would be very minimal (<$40,000) budget impact associated with this change, because Colorado Medicaid reimburses for abortion care so rarely.

Citations:

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1. Per CDPHE's 2021 vital statistics surveillance data, 65 abortions were provided in hospitals, vs. 11,310 in provider offices. https://docs.google.com/spreadsheets/d/1JbXiTDg5I6QrYMiIE3sOmbk4Q2vB_FVt/edit#gid=1640676108
2. Torres, A., Donovan, P., Dittes, N., & Forrest, J. D. (1986). Public Benefits and Costs of Government Funding forAbortion. Family Planning Perspectives, 18(3), 111–118. https://doi.org/10.2307/2135343
3. Colorado's public funding ban, Article V § 50 of the state constitution, prohibits the use of public funds for abortion care. This impacts people on Medicaid and all public employees – firefighters, teachers, park rangers, etc.
4. Gold, R. B., & Daley, D. (1991). Public Funding of Contraceptive, Sterilization and Abortion Services, Fiscal Year 1990. Family Planning Perspectives, 23(5), 204–211. https://doi.org/10.2307/2135754
5. Oregon Health Plan Fee-for-Service July 2022 Fee Schedule lists the reimbursement rate for 59840 and 59841 at $1,043.84 on p. 537. https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/fee-schedule0722.pdf California reimburses for 59841 at $1,600.
6. According to the CDPHE vital statistics surveillance data, 91.7% of abortion care was provided up to 12 wks gestation. https://docs.google.com/spreadsheets/d/1JbXiTDg5I6QrYMiIE3sOmbk4Q2vB_FVt/edit#gid=1640676108

Dental Services

Multiple stakeholders presented similar comments with the below main themes:

There were five (5) public comments on dental surgeries.

- All five commentators agreed that the existing rates were too low on specific services. High inflation and increased wages were identified as two root causes. In particular, it was noted that the hourly wage for hygienists is higher than the reimbursement for preventative services, resulting in a potential loss for dental practices in preventative care. Specific services mentioned include: preventative care, exams, cleaning, crowns, root canals, and service that requires a lab fee.
- It was confirmed that dental services will be doing a consolidated review this cycle with data available, as well as a full review next year.

Dr. Garry Van Genderen

We would like to thank the Rate Review committee for considering dentistry for a condensed review in 2023 and putting us on the agenda for this meeting. While every code needs review, as based on the 2023 Medicaid dental reimbursement fees we are nearly 20% behind inflation when compared to the 2015 Colorado Medicaid Dental fee schedule. The price of doing business has skyrocketed in dentistry in Colorado since 2015. In 2015 the minimum wage in

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Denver was $8.23 and a 6 month periodic exam for a patient paid $21. Now in 2023 the minimum wage in Denver is $17.29 and a 6 month periodic exam only pays $22. It is impossible to pay a doctor, assistant, and front desk/insurance coordinator the minimum wage with the current reimbursements, and these are not careers that should be getting paid minimum wage. This doesn't even account for overhead like property taxes, rent, utilities, ever increasing supply prices, ect. Regular adult cleanings are paying $41 while hygienists are asking for $50-$80 an hour depending on experience these days, we canno compete with PPO and FFS offices for staff. Dentists are strained and considering leaving Medicaid, or possibly even the state as over 28% of the state is now covered by Medicaid and that population is not allowed to be treated for compensation by a dentist who is out of network. We only have 395 active hygienists, 43 active endodontists (who do root canals), and 72 active oral surgeons (who treat oral cancer and deal with extreme infections) for the entire 1,658,678 people enrolled in Medicaid in Colorado. These are impossible numbers and a big reason why the numbers are like this is because of the fees that cause the providers to sustain financial harm by helping these Medicaid patients. The lack of providers has been causing patients to extract teeth due to pain that could have been saved if we had more people doing root canals, causing patients to wait longer for a biopsy as their oral cancer progresses until they can get into an oral surgeon, or patients to have their periodontal disease (gum disease), progress because they cannot get a timely cleaning. There are four main categories that we, the CDA Medicaid taskforce, have identified as desperately in need of an off cycle review. Those 4 categories are exams, cleanings, crowns, and root canals. Without urgent review of these fees several Medicaid providers may not survive until the full rate review in 2024 due to the drastic increases in cost to provide care. Due to various different materials and tooth positions these 4 categories amount to 24 procedure codes. These codes are currently being reimbursed at 34%-44% of the average fee listed in the 2022 ADA Survey of Dental Fees and it is making it nearly impossible to operate. The original setting of the reimbursements for these 24 codes in particular was deeply flawed. We would recommend that the fees be moved to 80% of the average fee listed in the ADA Survey of Dental fees. The CDA Medicaid taskforce is recommending the following codes for an out of cycle review.

The codes recommended for review are as follows:

Exams
D0120 - Periodic Oral Exam
D0140 - Limited Exam
D0150 - Comp Exam

Cleanings
D1110 - Adult Prophy
D1120 - Child Prophy
D4341 - Scaling and Root Planning
D4342 - Scaling and Root Planning 1-3 Teeth
D4910 - Perio Maint

Crowns
D2740 - Ceramic Crown
D2750 - Crown PFM High Noble

D2751 - PFM Base Metal
D2752 - PFM Noble Metal
D2753 - Crown PFT Titanium
D2790 - Gold Crown
D2791 - Cast Crown Base Metal
D2792 - Cast Crown Noble Metal
D2794 - Titanium Crown
D2930 - Stainless Steel Crown Primary Tooth

Root Canals
D3310 - Anterior Root Canal
D3320 - Bicuspid Root Canal
D3330 - Molar Root Canal
D3346 - Retreat Ant RCT
D3347 - Retreat Premolar RCT
D3348 - Retreat Molar RCT

Please let us know if there is anything that we can do and thank you for your consideration.

Dr. Michael Coughlin
Blue Spring Dental

1. In 2018, reimbursement for a New Patient exam (D0150) was $37.35. Today it is $39.43. In 2018 an adult cleaning (D1110) was $39.76. Today it is $41.97. An extraction (D7140) was $98.33, today it is $103.82. The rates seem to have increased ~5% from 2018 to today. Inflation for the same time frame has been ~20%. Should providers anticipate reimbursement to continue the trend of being unable to keep up with inflation while deciding if participating in these plans is a viable option for their practices long-term plans?
2. An adult cleaning (D1110) reimburses $41.97. The lowest hourly wage for a dental hygienist is ~$40/hr. At a minimum, it requires two auxiliary staff to support this appointment, one assistant to set up/break down the room, and one front desk staff. Each staff costs ~$18/hour. The shortest ethical amount of time a practitioner might schedule for this appointment is 40 minutes per patient. If the reimbursement of $41.97 per cleaning is reasonable, please provide feedback on how a practice is supposed to provide this service to even break even. Once factoring in office overhead, staffing, supplies, etc, every calculation I arrive at clearly shows adult cleanings as an appointment my practice loses money on. As a practitioner who prioritizes preventative care, I find it disheartening that the most common dental procedure is expected to be provided by my office at a loss. While I do my best to provide this service for my patients, I must admit the expectation that this is to be provided at a loss is the biggest reason I can see that would make me drop Colorado Medicaid from my office. If your rate review is unable to formulate a business model that shows this common dental procedure to be profitable for offices, then this procedure must be reimbursed at a fair market value.

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Jose Mena
Dental Director at Dental Aid

- They serve the population of Boulder County. Hoping that they [HCPF] might consider reducing the review cycle. A lot of providers in their area have stopped taking Medicaid patients.
- Currently the patient population is about 60% Medicaid and they see that increasing due to the fact that other providers are not able to continue with Medicaid. They want to increase access to care.

Michelle Montroy
Executive Director of Dental Aid

- They [Dental Aid] are struggling to be profitable and making hard decisions every day.
- Their mission is to increase access, but the reimbursement rates are not covering their costs.
- Discussed condensed review vs full review – Kevin from HCPF said that we don't know exactly how the JBC would take that – there have been times in the past they have reviewed things multiple years in a row. Some at their request, some not. Putting things forward when it's not up for review can be a little off-putting. That may not be a reason not to do it, but wanted to share how it may be perceived.

Garry Van Genderen
Ideal Dental

- Discussed procedure for an off-cycle review, and what is a reasonable number of codes to do in an off-cycle review.
- Kevin from HCPF said they cannot use All Payer Claim Database data due to the need to request far in advance, so data limitations are a major factor in a condensed/off-cycle review.
- Confirmed if he [Gary] sent in a bunch of recommended benchmarks and percentages it would help HCPF in their review process due to limitations in data.

Dr. Leah Schulz
Colorado Dental Association

The Colorado Dental Association appreciates the Dental condensed rate review process this year, with a full rate review next year. With steadily increasing costs coinciding with stagnant

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Medicaid reimbursement rates, year after year, many dentists can no longer afford to accept Medicaid. This contributes to provider network inadequacy and thus negatively impacts the oral health of millions of Coloradans. It is essential to this condensed rate review process that this Committee select the meaningful codes for review. These codes are not necessarily the most significantly under-reimbursed but should be comprised of codes that address the immediate needs of dentists and patients, prioritizing codes that would be frequently utilized and that have the greatest impact on oral health. Several months ago, the CDA's Medicaid Taskforce, comprised of general and specialty dentists in both private practice and community health, all of whom are Medicaid enrolled dentists, provided this Committee with a list of 24 codes that we hoped would be addressed first. Those codes were the result of much deliberation and discussion. I am happy to resubmit those codes as written testimony immediately hereafter, if needed. I request that this Committee move forward with advocating to JBC that our 24 selected codes be the first to receive a rate increase. I also want to bring to the Committee's attention that both of the Fee Schedules used for your proposed fee adjustments are outdated. When using the most current fee schedules, you will see that Dental's fees are, in fact, 45% of the benchmark, not the 48% presented on this agenda. The ADA Fee Schedule shown is from 2020; there is a more recent fee schedule, from 2022. Equally, the CO Medicaid Fee Schedule is from 7/1/2022, but there is a more recent CO Medicaid Fee Schedule available, published 7/1/2023. Current fee schedules should be used to create the most accurate proposal. We consolidated all the current codes, 2022 and 2023 Medicaid Fee Schedules, and the 2020 and 2022 ADA Fee Schedules for your convenience, which we are happy to share with you immediately hereafter, if needed, to make a more accurate fee proposal. Thank you for your time and I'm happy to answer any questions you may have.

Arielle Valenti
Mango House Dental

I'm Arielle Valenti, a dental hygienist with Mango House Dental Clinic, a private practice in Aurora, Colorado. I helped establish our clinic 6 years ago. We are deliberately located in the poorest zip code in the Denver metro area so that we can be easily accessible to our patients. We exclusively serve refugees, asylees and the undocumented population, and over 90% of our patients receive Medicaid. The codes selected for review this year will have little to no impact on those struggling dental hygienists who accept Medicaid in Colorado. Dental hygienists are not receiving any acknowledgement in this review but as a clinic we cannot afford to ignore this group of providers when current reimbursements do not cover the average hourly wage of a dental hygienist in Colorado (and that doesn't even include other overhead). Dental hygienists survive based on these 4 codes: D1110 (adult prophylaxis, or routine cleaning); D4341 (scaling and root planing of 4 or more teeth, also known as deep cleaning); D4342 (scaling and root planing of 1 to 3 teeth, also a deep cleaning but less extensive); and D4910 (periodontal maintenance, which is scheduled every 3 to 4 months after a patient undergoes deep cleaning to help maintain their stable oral health). We would be deeply grateful if the rate review committee would add these 4 codes to this year's out of cycle rate review. Thank you so much for your consideration.

Jennifer Rudder
Mango House

Hello, my name is Jennifer Rudder, Office Manager for Mango House, a dental clinic that mainly serves refugees in Aurora, Colorado. The codes selected for review this year will have little to no impact on the struggling dental hygienists who accept Medicaid in Colorado. Hygienists are being ignored as a class of providers entirely in this review, and these providers cannot afford to be ignored with reimbursements that do not even cover the average hourly wage of a dental hygienist in Colorado, not to mention other overhead. Dental hygienists mainly survive based on 4 codes D1110 Adult Prophy, D4910 Periodontal Maintenance, D4341 Scaling and root planning, and D4342 1-3 Tooth Scaling and root planning. We would be so grateful if the rate review committee could add these 4 codes to this year's out of cycle rate review. Thank you.

Molly Pereira
Colorado Dental Association

I'm seeking clarification on the codes being reviewed today. While the codes noted in the presentation are in need of review, they are not necessarily the 24 most utilized codes. We were under the impression that this limited review would address the 24 most utilized codes to make the most meaningful difference. Just seeking clarification. Thank you!

Jeffrey Lodl
Colorado Dental Association Medicaid Task Force

I have been an Adult Medicaid Provider since it's inception. Also part of CDA Task Force and would like to speak to the 24 codes we selected for rate review.

Arielle Valenti
Mango House Dental

My name is Arielle Valenti. I'm a dental hygienist speaking as the clinical director and primary provider at Mango House Dental Clinic, a private practice in Aurora with a patient population comprised of refugees, asylees and undocumented folks. Over 90% of our patients receive Medicaid. The codes selected for review this year won't have much impact, if any at all, on those struggling dental hygienists who accept Medicaid in Colorado. Dental hygienists are not receiving any acknowledgement in this review but as a clinic serving Medicaid recipients almost exclusively we cannot afford to ignore this group of providers. Current reimbursements do not cover the average hourly wage of a dental hygienist in Colorado (and that doesn't even include other overhead). Dental hygienists survive based on these 4 codes: D1110 (which is an adult prophylaxis, or routine cleaning); D4341 (which is scaling and root planing of 4 or more

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teeth, also known as deep cleaning); D4342 (which is scaling and root planing of 1 to 3 teeth, also a deep cleaning but less extensive); and D4910 (periodontal maintenance after a deep cleaning). Our clinic would be deeply grateful if the rate review committee would add these 4 codes to this year's out of cycle rate review. We really appreciate your consideration and the opportunity to speak.

Garry Van Genderen
Colorado Dental Association

Hello my name is Dr. Garry Van Genderen. I am a member of the Colorado Dental Association Medicaid Taskforce. The CDA Medicaid task force over several months of careful deliberation picked 24 codes that desperately needed to be revisited this year in regards to reimbursement rates that could not wait until the full review next year. These codes have been emailed to the rate review committee. The codes listed in the presentation are not the codes we recommend and the listed codes would not have a meaningful impact on dentistry. The 24 codes that were selected by the CDA address the areas of exams and cleanings which are the end goal for stable oral health. Root canals which are some of the most painful and emergent issues in dentistry, and crowns which have a spectacular record of protecting severely damaged teeth for decades. All of these essential procedures are at risk of not being offered to Medicaid patients due to the terrible reimbursement rates. Please review as many codes as you want but please make sure to include the 24 codes we painstakingly picked in the process.

Dr. Leah Schulz
Colorado Dental Association

1. Fee Schedules used were outdated: please use the ADA 2022 and the Medicaid 2023 fee schedules for the most accurate reimbursement adjustment
2. The most poorly reimbursed codes are not the codes that the dental stakeholders suggest that we improve immediately. We have emailed several times a list of preferred 24 codes that we feel would be the most impactful. These codes were thoughtfully and deliberately selected based on the anticipated impact to patients oral health outcomes.

Dr Josh Jackstien
CarePoint Anesthesia Team 92

To whom it may concern,

I am writing to speak in favor of revising the Colorado medicaid fee schedule specifically for dental codes D9222 and D9223, deep sedation/general anesthesia. My colleagues and I are practicing dentist anesthesiologists here in Colorado. Dental anesthesia is the newest ADA

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endorsed dental specialty and we provide our anesthesia services for our other dental colleagues and their patients. We don’t bill any other typical dental services other than anesthesia, therefore our practices success is heavily tied to the reimbursement rates for these codes. For a long time, oral surgery was the only specialty within dentistry that billed these codes and the fee schedule and policies that were established in Colorado were based on its use by oral surgeons for the way deep sedation/general anesthesia was provided by the traditional oral surgery practice. Dental Anesthesia practices are very different than our oral surgery colleagues. One of the main focuses of a dental anesthesia practice is working alongside our pediatric dental colleagues treating their full mouth rehabilitation cases on pediatric patients or patients with special treatment needs. Thankfully the majority of the patients we see are covered by the state’s medicaid program. Many of the dental anesthesia practices that choose to accept medicaid are heavily reliant on their ability to effectively bill medicaid and receive fair reimbursement. Again, the services that dentist anesthesiologists provide and the circumstances in which they are provided are typically very different than our Oral Surgery colleagues. Oral surgeons typically provide anesthesia for their own surgical patients and thus bill for the anesthesia codes in addition to the dental surgical codes. In this situation, anesthesia becomes an adjunct billable service for them, which helps to improve the overall surgical experience for themselves as the operator-anesthetist and the experience for their patients. However, the surgical codes are their primary source of revenue. Any issues that they may encounter billing anesthesia are usually offset by the ability to bill their other surgical codes. In the case of dentist anesthesiologists, the anesthesia codes are the only codes billed and thus the only source of revenue. In addition, the additional supplies and medications that are used during a general anesthetic case on pediatric patients needing full mouth rehabilitation can be much more expensive than what it takes to complete wisdom teeth removal. We also often work along side our oral surgeon colleagues for thirds molar extractions. Those cases are typically not at the same level of anesthesia as our pediatric patients and are not nearly as long. But these two very different modalities of treatment and anesthesia are reimbursed the same. This stretches the ability to provide our services, especially post covid when the cost of every part of our business has increased as much as 30-40%. Unfortunately, the rate adjustments have not kept pace with inflationary factors. Many states, have a specialists fee schedule for medicaid services. This is to account for the additional training and expertise that these specialists have in order to provide a more focused and specialized approach to their care. The ability to access the specialists fee schedule is based on the specific taxonomy codes that are linked to a providers NPI number. These rates are usually higher than those of their non specialty specific code counter parts. Our expertise and approach in providing anesthesia far exceeds that of a general dentist providing sedation on their own patients, yet their reimbursement is equal to that of ours. After the completion of a 3 year residency, dentist anesthesiologists are providing the same level of anesthesia as the hospital, but in the office setting. The ability for dentist anesthesiologists to provide general anesthesia services for patients in the office setting potentially saves thousands of medicaid dollars on every case since the case does not need to be referred to the hospital for the completion of the dental treatment. The demand for our office based services is high and any financial or administrative limitations in our ability to bill for our services significantly increases the cost of care, and potentially can decrease access to care for the patients that need it most.

Currently, the reimbursement for the billable codes of moderate sedation and general anesthesia are the same. The required care, the depth of knowledge, the required equipment and supplies for the provision of general anesthesia are far more complex than that of moderate sedation. The administrative burden to bill and the overall expense that is required to provide general anesthesia far exceeds that of moderate sedation. We ask that this also be considered when assessing the need to adjust the CDT codes associated with billing deep sedation or general anesthesia. We are also currently working with Dentaquest and the state to determine if modifications are needed on the billing/administrative systems side. Currently they are onerous and dependent on factors that are considered by some as unreasonable. We appreciate your attention to the issues outlined in this letter and would love to help educate anyone who is interested in better understanding who dentist anesthesiologists are and what they do. We are still a relatively new specialty and understand that there are many unique things about our services that are not yet understood. We welcome the opportunity to help make reasonable and necessary changes to the process and reimbursement for anesthesia services provided in dentistry. Please let us know how we can help.

Kathy Paglione-Hurd, CDA, EFDA, Practice Administrator
Mark D. Hurd, DDS

Hello,

I participated in the ZOOM meeting on April 21, 2023 regarding the upcoming rate review. I wanted to add some additional input as there were time constraints at the meeting. All the providers had valuable input regarding the cost of providing care to patients. I would like to add our experience of providing care to Medicaid (Dentaquest) recipients. Our community has a large number of patients covered under Medicaid. Required PPE has increased 40%-50%. We respectfully ask for consideration of rate increases in the following areas:

1. Crown (ie: D2740, D2750, D2790) Bridge (D6740, D6245, D6750, D6790, etc), Denture (ie: D5110, D5120, D5130, D5140) Partial (ie: D5211, D5212, D5213, D5214, D5225, D5226), Denture and Partial Repairs (ie: D55190, D5512, D5520, D5610, D5611, D5612, D5620, D5630, D5640, D5650, D5660, D5740, D5741, D5760, D5761). Lab fees for all these procedures have increased 25%-35%. Materials used such as impression material, temporary crown, cement, etc. have increased approximately 25%-30%.
2. Preventative Care (ie: D0120, D0140, D0150, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1208, D1351,D4341, D4342, D4345, D4910). Preventative care is so very important. Lack of regular preventative care can create systemic health problems and the need for costly restorative care. In our office we have an aggressive recall program which includes prescheduling patient recall visits, contacting patients that have missed their appointments or ar past due. Supply costs have increased 23%-35%. We provide a toothbrush and floss to every patient. Dental hygienist average wages in our community are $42.00 - $50.00 per hour. Dental assistant average hourly wage in our community is $18.00-$25.00. The cost to provide preventative care is not sustainable under the current rate structure.
3. Endodontic Procedures (ie: D3221, D3310, D3320, D3330, D3340, D3346, D3347, D3348). The materials and instrumentation have increased 20%-30%. Many offices do

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not provide endodontic care to patients. Endodontists (endodontic specialist) do not participate/accept Medicaid/Dentaquest patients. Patients are left extraction as the only treatment option. Restorative fees (ie: D2391, D2392, D2393, D2394) fees are generally in line with reimbursement of many commercial dental PPO insurance plans. We believe a rate increase in the above mentioned areas would help provide consistent, regular care for Medicaid/Dentaquest recipients. We also believe a patient copay such as the past $4.00 copay would also help offset the increased cost of providing dental care.

Please do not hesitate to contact me should you need any additional information.

Sarah Hayward

Hi, we are not able to attend the meeting next week, but I would like to voice a few concerns. We have two offices who take a high volume of Medicaid, we have worked really hard to have providers who offer molar endo and wisdom teeth with sedation. We feel because we are one of the only offices in our area that will do molar endo and Wisdom teeth we should get higher rates for these procedures. We literally get referrals all the time from other offices that cannot do root canals and we want to help all the patients we can so they can save their teeth but the reimbursements do make it hard. Is there a way to make an exception to get higher rates on these procedures we do that other offices do not offer? Are there any grants or programs that help private practice offices that offer a high volume of Medicaid. We are so happy to do it and we love our patients but it is becoming a challenge! Last concern is the credentialing process- let's be honest it is a nightmare to credential a new provider. Unhelpful customer service, no clear directions and no clear timeline for when our providers can begin to work.

Garry Van Genderen
Colorado Dental Association

Hello,

Here are the 24 top priority codes that the CDA recommends for extra evaluation by the rate review committee in our off cycle review. For the titanium based crowns which do not appear on the ADA Survey of Dental fees we recommend setting them at the same rate as either nobel crowns or ceramic crowns.

The codes recommended for review are as follows:

Exams
D0120 - Periodic Oral Exam
D0140 - Limited Exam
D0150 - Comp Exam

Cleanings

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D1110 - Adult Prophy
D1120 - Child Prophy
D4341 - Scaling and Root Planning
D4342 - Scaling and Root Planning 1-3 Teeth
D4910 - Perio Maint

Crowns
D2740 - Ceramic Crown
D2750 - Crown PFM High Noble
D2751 - PFM Base Metal
D2752 - PFM Noble Metal
D2753 - Crown PFT Titanium
D2790 - Gold Crown
D2791 - Cast Crown Base Metal
D2792 - Cast Crown Noble Metal
D2794 - Titanium Crown
D2930 - Stainless Steel Crown Primary Tooth

Root Canals
D3310 - Anterior Root Canal
D3320 - Bicuspid Root Canal
D3330 - Molar Root Canal
D3346 - Retreat Ant RCT
D3347 - Retreat Premolar RCT
D3348 - Retreat Molar RCT

Dr. Coughlin
Blue Springs Family Dental

Good afternoon! I have a few questions regarding tomorrow's meeting. First, is this session available on demand to watch after the meeting has concluded? Or if I stream this while away from the session, is recording enabled so I can watch the answers to my concerns?

Additionally, I have two points of concern:

1. In 2018, reimbursement for a New Patient exam (D0150) was $37.35. Today it is $39.43. In 2018 an adult cleaning (D1110) was $39.76. Today it is $41.97. An extraction (D7140) was $98.33, today it is $103.82. The rates seem to have increased ~5% from 2018 to today. Inflation for the same time frame has been ~20%. Should providers anticipate reimbursement to continue the trend of being unable to keep up with inflation while deciding if participating in these plans is a viable option for their practices long-term plans?
2. An adult cleaning (D1110) reimburses $41.97. The lowest hourly wage for a dental hygienist is ~$40/hr. At a minimum, it requires two auxiliary staff to support this appointment, one assistant to set up/break down the room, and one front desk staff. Each staff costs ~$18/hour. The shortest ethical amount of time a practitioner might schedule for this appointment is 40 minutes per patient. If the reimbursement of

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$41.97 per cleaning is reasonable, please provide feedback on how a practice is supposed to provide this service to even break even. Once factoring in office overhead, staffing, supplies, etc, every calculation I arrive at clearly shows adult cleanings as an appointment my practice loses money on. As a practitioner who prioritizes preventative care, I find it disheartening that the most common dental procedure is expected to be provided by my office at a loss. While I do my best to provide this service for my patients, I must admit the expectation that this is to be provided at a loss is the biggest reason I can see that would make me drop Colorado Medicaid from my office. If your rate review is unable to formulate a business model that shows this common dental procedure to be profitable for offices, then this procedure must be reimbursed at a fair market value.

Thank you for passing along these questions for your review. I will attempt to join the meeting tomorrow, but in case I'm unable to do so, please advise regarding recording options. My goal is to provide some feedback so I can continue to serve these patients, and hope that some clarity will allow me to continue to do so. Thank you

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Kathy Paglione-Hurd, CDA, EFDA, Practice Administrator

My name is Kathy Paglione-Hurd. I am the practice administrator from Dr Mark Hurd's office in Pueblo, CO (NPI: 1265632871). We would like to offer some feedback re: the upcoming provider rate review. Supplies and lab fees have increased considerably. We would like to request an increase in reimbursement for procedures that have a lab fee ie: crowns, bridges, dentures, denture repairs, denture relines, partial dentures, partial denture repairs, partial denture relines. The impression materials used for these procedures have increased approximately 40%. Lab fees have increased 25%-35%. Employee wages have also increased considerabley. Hygienist wages in Pueblo average $42.00-$50.00 per hour. At the current diagnostic and preventative reimbursement, office are losing revenue at each continuing care appointment. Dental assistant wages average $18.00-$25.00. We would like to request an increase in rate reimbursement. Materials used for endodontic procedures have increased 25% to 30%. Endodontist do not accept Dentaquest. Being able to provide endodontic care in our office is a benefit for Dentaquest recipients. We would like to request an increase in rate reimbursement. Restorative reimbursement seems to be in line with major commercial insurers.

Dr. Leah Schulz
Colorado Dental Association

I am writing regarding Dental’s consolidated rate review process (in process this morning, 7/24/23), as a continuation of the 7/14/23 meeting.

1. The Colorado Dental Association appreciates the use of the ADA Fee Schedule as the benchmark, but would like the Committee to please use the most updated fee

schedule. The fee schedule used was the ADA fee schedule from 2020; there is an ADA 2022 Fee Schedule available.
2. We request that the Committee please use the most updated Medicaid fee schedule. The fee schedule used was from 7/2022; there is an updated Medicaid Fee Schedule from 7/2023. We have consolidated all available fees from both the current ADA and Medicaid Fee Schedules (see attached), in an effort to reduce the Committee's administrative burden in collecting this information. Please see the attached spreadsheet, "All Inclusive" tab.
3. The Colorado Dental Association represents 70% of dentists across the state; we are the primary provider stakeholder. We reviewed every CDT code reimbursement rate and thoughtfully selected 24 codes that we felt would be the most impactful. MPRACC seems to have selected the lowest reimbursed codes as a percentage of the two outdated fee schedules. While this may make mathematical sense, the codes selected will have very little impact on oral health outcomes for patients, and will do little to help retain and recruit an adequate provider network. Please reconsider the 24 codes selected to align with the CDA's selected codes. The second tab on the attached spreadsheet lists the CDA's selected codes, with corresponding current fee schedules.

Nate
Colorado Dental Association

I would like to speak on behalf of dentists in our state that are invested in serving the public good and are concerned about the oral health and well being of our community

---

Dr. Christopher Morris
Colorado Dental Association task force committee

CDA advisement on reimbursement rates

Digestive System Surgeries

No public comment.

Musculoskeletal System Surgeries

No public comment.

Cardiovascular System Surgeries

Multiple stakeholders presented similar comments with the below main themes:

- All three providers talked about Verithena, and the benefits of the procedures.
- All three agreed that the rate does not cover the supply costs of performing the service. All three thought there may have been a mistake or typo when determining the rate.

Dr. Gordon Gibbs

Voicing support of appropriate reimbursement of Varithena (CPT codes 36465/36466) by Medicaid

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Dr. David Pinsinski

This treatment is being offered and reimbursed by Medicare. I would like to have this treatment available for my Medicaid patients as well.

Courtney Delbridge
Varithena

I wanted to follow up because it seems there has been some confusion around the review of these codes. They fall under vascular surgeries, and we were under the impression this category of codes went into review November 2022 as Dr. Pinsinski stated. Can you confirm that is the case and if so, when and how the treating physicians will be notified of a rate change if one is made? I also wanted to share another study that was recently published regarding patients with active wounds. Varithena is often the first choice in treating these patients as it is the only non-catheter based procedure therefore the only FDA approved procedure able to get under a wound bed. Attached, you will see the summary and the great results when treating these patients with Varithena. This study is just additional proof on top of an already significant amount of clinical data in favor of Varithena. If there is more we can provide you with, please let me know. Thank you very much for your time and consideration.

Dr. David Pinsinski

Hi Michelle, I wanted to thank you for the chance to speak at the Medicaid rate review meeting on 4/21/2023 to discuss Varithena. I appreciate you allowing me to share my experiences and my request to have CPT codes 36465 and 36466 evaluated again. These codes

have been under review since November, 2022 for what appears to be the wrong reimbursement amount. I am hopeful the reimbursement changes will go into effect shortly. Please let me know if there is anything I can help you with or any general information regarding Varithena. Thanks again for your help.

Marjorie (Margie) Hans, RN BSN
Peripheral Interventions

Both Varithena and TheraSphere/Y-90 are considered medical devices and do not have NDC's. Shared below is info below on both. I am hopeful you can look at the current rates and how they differ greatly as compared to other states. Please also see the attached data as well as the info below. I am more than happy to answer any additional questions you may have and am eager for you to look at doing an expedited review of both procedures so the CO Medicaid constituents have access.

Varithena

The procedure codes for Varithena are 36465 and 36466 and I have attached a brief description and below is more helpful information as background for our request for a rate review.

- These codes do not represent a significant increase in procedures as this endovenous procedure would be used instead of endovenous radiofrequency ablation (36475, 36476) or endovenous laser ablation (36478, 36479)
- CPT codes representing endovenous ablation procedures described above (36475, 36476, 36478, 36479) are included in the Colorado fee schedule at appropriate rate levels compared to Medicare and other state Medicaid programs and relative to the costs of providing the procedure.
- The procedure these codes represent offers advantages in patient comfort, procedure related risk reduction, and offer more flexibility with difficult patient anatomy over endovenous RF and laser ablations.
- Currently 300,000 treatments in the last 3.5 years with no significant adverse events
- Robust clinical trials leading to FDA approval
- 1,333 patients studied
- Truncal veins were the focus of the trials(There were no exclusions in the pivotal trials for vein size, anatomy, or previous treatment; GSV diameters up to 25.9mm)
- Only 3.4% of truncal veins in clinical trials required retreatment of the same vein in a pivotal trial (data on file)
- The Randomized Controlled Trials needed for FDA approval include a proven multiple step procedure intended to deliver consistent patient outcomes.
- Only one code, either 36465, or 36466 would be used per procedure as 36465 represents a single truncal vein procedure, and 36466 represents a multiple truncal vein procedure thus only one code can be used per procedure.
- The FDA approved sclerosant used in these endovenous ablation procedures is included in the reimbursement for 36465, and 36466, and cannot be billed separately.
- Robust Peer-reviewed data post pivotal trials (>480 patients since 2020)

- 94.4% GSV closure rate in 250 patient retrospective study2
- 95% closure rate of majority truncal vein retrospective study of 122 patients, 157 limbs3
- 96% closure rate of majority truncal vein retrospective study of 49 patients, 201 limbs4
- 93% closure rate of truncal veins in a 60 patient, multicenter, prospective observational study at 6 months5
- 27 peer-reviewed papers published relating to the safety of Varithena since FDA approval in 20136
- Randomized, blinded, multicenter study proving efficacy in symptom relief and improvement in vein appearance7

1. Todd KL III, Wright DI, and the VANISH-2 Investigator Group. The VANISH-2 study: a randomized, blinded, multicenter study to evaluate the efficacy and safety of polidocanol endovenous microfoam 0.5% and 1.0% compared with placebo for the treatment of saphenofemoral junction incompetence. Phlebology. 2014;29(9):608- 618. doi:10.1177/0268355513497709.
2. Deak ST. J Vasc Surg Venous Lymphat Disord. 2018; 6: 477-84.
3. Jimenez, J. C., & Lawrence, P. F. (2020). Adjunctive techniques to minimize thrombotic complications following microfoam sclerotherapy of saphenous trunks and tributaries. Journal of Vascular Surgery, 9(4), 904–909. https://doi.org/10.1016/s0741-5214(03)01557-x
4. Jimenez, J. C., & Lawrence, P. F. (2022). Endovenous microfoam ablation of below knee superficial truncal veins is safe and effective in patients with prior saphenous treatment across a wide range of CEAP classes. Journal of Vascular Surgery, 10(2), 390–394. https://doi.org/10.1016/s0741-5214(03)01557-x
5. Kim PS, Elias S, Gasparis A, Labropoulos,N. Results of Polidocanol Endovenous Microfoam in clinical practice, J Vasc Surg: Venous and Lymphatic Disorders (2020), doi: https://doi.org/10.1016/j.jvsv.2020.04.015
6. Varithena bibliography available upon request
7. Todd KL and Wright DI. Durability of treatment effect with polidocanol endovenous microfoam on varicose vein symptoms and appearance (VANISH-2). J Vasc Surg: Venous and Lymphatic Disorders. 2015; 3(3): 258-264.

Colorado Medicare Reimbursement per CMS Fee Schedule Look-up tool accessed 6/14/2022

HCPCS Code	Modifier	Short Description	Mac Locality (Colorado)	Non-Facility Price	GPCI Work	GPCI PE	GPCI MP	Proc Stat	Work RVU	Fully Implemented Non-FAC PE RVU	Fully Implemented Facility PE RVU	MP RVU	Fully Implemented Non-Fac Total
36465		Njx noncmpnd sclrsnt 1 vein	411201	$1,466.76	1.001	1.047	0.767	A	2.35	37.92	0.68	0.43	40.7
36466		Njx noncmpnd sclrsnt mlt vn	411201	$1,619.91	1.001	1.047	0.767	A	3	41.43	0.94	0.56	44.99

Additional Info on neighboring states:

AZ rates

Payer	Document	Code	Modifier	Service	Weight	Rate	Facility	Non-Facility
Arizona Medicaid	Outpatient Hospital	36465				$1,407.92		
Arizona Medicaid	Outpatient Hospital	36465				$1,243.64		
Arizona Medicaid	Ambulatory Surgical Cente ...	36465				$819.03		
Arizona Medicaid	Physician	36465					$122.22	$1,530.14

TX

Payer	Document	Code	Modifier	Service	Weight	Rate	Facility	Non-Facility
Texas Medicaid	Nurse Practitioner	36465		2			$89.86	$1,109.05
Texas Medicaid	Nurse Practitioner	36465		2			$85.58	$1,056.22
Texas Medicaid	Physician	36465		2			$97.67	$1,205.49
Texas Medicaid	Physician	36465		2			$93.02	$1,148.07
Texas Medicaid	Ophthalmology	36465		2			$97.67	$1,205.49
Texas Medicaid	Ophthalmology	36465		2			$93.02	$1,148.07
Texas Medicaid	Physician- Other	36465		2			$97.67	$1,205.49
Texas Medicaid	Physician- Other	36465		2			$93.02	$1,148.07
Texas Medicaid	Pathologist	36465		2			$97.67	$1,205.49
Texas Medicaid	Pathologist	36465		2			$93.02	$1,148.07
Texas Medicaid	Radiation Therapy	36465		2			$97.67	$1,205.49
Texas Medicaid	Radiation Therapy	36465		2			$93.02	$1,148.07
Texas Medicaid	Radiologist	36465		2			$97.67	$1,205.49
Texas Medicaid	Radiologist	36465		2			$93.02	$1,148.07
Texas Medicaid	Physician Assistant - Med ...	36465		2			$89.86	$1,109.05
Texas Medicaid	Physician Assistant - Med ...	36465		2			$85.58	$1,056.22

TheraSphere:

TheraSphere consists of insoluble glass microspheres where yttrium-90 is an integral constituent of the glass. The product is administered by a physician into an artery of the patient's liver through a catheter, which allows the treatment to be delivered directly to the tumor via blood flow. The microspheres, being unable to pass through the vasculature of the liver due

to arteriolar capillary blockade, are trapped in the tumor and exert a local radiotherapeutic effect with some concurrent damage to surrounding normal liver tissue. In the United States, TheraSphere is indicated for use as selective internal radiation therapy (SIRT) for local tumor control of solitary tumors (1-8 cm in diameter), in patients with unresectable hepatocellular carcinoma (HCC), Child-Pugh Score A cirrhosis, well-compensated liver function, no macrovascular invasion, and good performance status Current Reimbursement for Y-90 TheraSphere for Colorado Medicaid. An S-code is on the fee schedule when in fact the C-2616 should be considered to be used

Payer	Document	Code	Modifier	Service	Weight	Rate
Colorado Medicaid (FFS)	Professional Rates - Fee ...	C2616				$0.00
Colorado Medicaid (FFS)	Professional Rates - Fee ...	S2095				$987.42
Colorado Medicaid (FFS)	General - Fee Schedule	S2095				$987.42

Comparable Medicaid rates for surrounding states

Payer	Document	Code	Modifier	Service	Weight	Rate
Arizona Medicaid (FFS)	Outpatient Hospital - Fee ...	C2616				$12,613.29
Arizona Medicaid (FFS)	Ambulatory Surgical Cente ...	C2616				$16,875.05
New Mexico Medicaid (FFS)	OPPS Codes - Fee Schedule	C2616				$15,779.35

Gordon F. Gibbs, MD
Founder, Chief Medical Executive

This email is to thank you for the opportunity to speak during the recent rate review committee meeting April 21 and to thank you for considering a change in reimbursement for Varithena (CPT codes 36465 and 36466). Varithena is a great procedure and is a very useful tool for treating patients with lower extremity venous disease. Our providers at American Vein and Vascular Institute use it regularly but cannot use it for Medicaid patients as the current reimbursement rate does not even cover the procedure supply costs. I believe a reimbursement closer to thermal ablation (CPT codes 36475 or 36478) or Venaseal (CPT code 36482) is more appropriate. If the rate change is deemed appropriate, do you have an idea of when that may go into effect?

Melissa Ramirez
Mountain Vein Care, PLLC

My name is Melissa Ramirez, and I am the insurance coordinator for Dr. Carl Dando at Mountain Vein Care in Avon Colorado.

I was given your name by our Varithena/Boston Scientific representative, Courtney Delbridge, regarding reimbursement for Medicaid patients. We were told that as of 7/1/2023 Medicaid had increased the reimbursement rate for CPT codes 36465 and 36466, Varithena, to an appropriate amount of $1010.09 (36465)I received an authorization, verified fee schedule reimbursement to be sure everything was as it was stated.Claim was processed and paid at the, now changed, current stated reimbursement rate of $99.85. I reached back out to Courtney, or Varithena rep, and she had found out from a few other providers of the change.No communication at all from Medicaid. As a medical provider, we continue to provide excellent service to your members andthis is completely unacceptable. We have had no choice but to accept low reimbursement rates for years, but this really took us by surprise.I don't understand why you would not have thought it would be appropriate to reach out to providers to let them know that there had been this significant change in the fee

schedule. Especially because this was a very new change and had been in the works for quite some time.

I called and spoke with Jennifer REF 2199146 who sees no record of the fee schedule change as of 7/1/23 to $1010.09.

Thank you for your time and reconsideration of reimbursement of charges submitted for your member, our patient.

Pamela Atwell
Sr. Director Market Access and Payor Relations

Dear State of Colorado,

It has come to our attention that certain hysteroscopy procedure codes have not received a physician reimbursement increase in several years or, updated to include procedures performed in a cost-effective non-facility (office) setting per CMS guidelines established in 2017. Therefore, fall below the CMS suggested reimbursement rates for the State of Colorado Medicaid plan.
We are kindly requesting a rate review to determine if reimbursement can be adjusted to meet the financial/cost increases over the years that are associated with providing these critical procedures to your health plan members.
Please take a moment to review the State of Colorado published reimbursement, billing, and ordering systems.

Compare them to CMS established reimbursement rates.
https://www.cms.gov/Medicare/Medicaid

CPT Code	CMS Procedure Description	Point of Care	State of CO 2023 Published Payment	2023 Median State Medicaid Payment Rates	2023 Medicare Unadjusted National Payment
58555	Hysteroscopy, diagnostic	Non-Facility / In-Office Setting	$177	$330	$363
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy	Non-Facility / In-Office Setting	$231	$976	$1,339
58562	Foreign body removal	Non-Facility / In-Office Setting	$230	$360	$432
58563	Hysteroscopy with ablation	Non-Facility / In-Office Setting	$1,473	$2,016	$2,131

“Incentivization for office operative hysteroscopy took a notable step in 2017, when the Centers for Medicare and Medicaid Services increased non-facility (office) reimbursement from 2016 by 237% from 11.44 RVU (relative value unit) to 38.51 RVU for hysteroscopy with surgical sampling (CPT 58558).”[1]

Physicians modified the way they provide care during and post Covid-19. Physicians are performing these critically needed procedures in a cost-effective non-facility (office) setting allowing for quick access to care without the risk of going into a hospital or outpatient surgical facility. Some localities have not recognized and reimbursed physicians for these procedures when performed in the non-facility (office) setting (POS 11) despite the preponderance of published clinical evidence which supports hysteroscopy performed in the physician’s office as *“being less expensive, more convenient for the physician and patient, and offering faster recovery and less time off work for the patient.”*[2] (ACOG Practice Bulletin Number 128)
CooperSurgical® is notifying all customers and business associates about this suggested change, and we would appreciate your partnership in helping your health plan members receive access to care that is efficient and cost effective. For any questions, contact CooperSurgical at 1.877.213.0459 or send communications to reimbursementsupport@CooperSurgical.com.

Clinical Information:
“Hysteroscopy may be performed in an office setting or in the operating room, with office hysteroscopy being less expensive, more convenient for the physician and patient, and offering faster recovery and less time off work for the patient.”[2]

“There exists a relatively robust body of evidence supporting the safety, effectiveness, and patient satisfaction with hysteroscopic surgery performed outside of the institution and without systemic anesthesia.”[3]

“Several recent studies addressing the issue have concluded that moving hysteroscopic procedures from the operating room (OR) to the office setting allows for streamline processes that are cost-effective, enhance physician productivity, and improve patient satisfaction.”[4]

“The ability to look inside the uterus to diagnose anatomic abnormalities that affect reproductive health and underlying gynecologic disorders is an invaluable tool for the modern gynecologist. Doing that in the office not only offers the benefit of convenience for the patient and the surgeon, but also has the potential to contribute significantly to overall reductions in health care costs.”[5]

“Potential benefits of office hysteroscopy include patient and physician convenience, avoidance of general anesthesia, less patient anxiety related to familiarity with the office setting, cost effectiveness, and efficient use of the operating room for more complex hysteroscopic cases.”[6]

Relevant CooperSurgical products include:
- Endosee® Advance
- Mara® Water Vapor Ablation System

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References:

ACOG guidelines and published studies advocating for greater use of in-office hysteroscopic procedures:

1. Parry JP, Isaacson K. Hysteroscopy, and why macroscopic uterine factors matter for fertility. Fertil Steril. 2019;112:203-210.
2. ACOG Practice Bulletin Number 128. Diagnosis of Abnormal Uterine Bleeding in Reproductive Aged Women. July 2012.
3. Malcolm G. Munro MD, Jamie L. Kasiewicz BS, Vrunda B. Desai MD: Office Versus Institutional Operative Hysteroscopy: An economic model. The Journal of Minimally Invasive Gynecology (2021).
4. Christina Alicia Salazar, Keith B Isaacson: Office Operative Hysteroscopy: An update: J Minim Invasive Gynecology (2018) 2018 Feb;25(2):199-208. Doi:10.1016.
5. Anderson TL. Hand-held digital hysteroscopy system a game-changer. Contemp ObGyn. https://www.contemporaryobgyn.net/view/hand-held-digital-hysteroscopy-system-game-changer Updated September 13, 2016. Accessed May 8, 2019.
6. The use of hysteroscopy for the diagnosis and treatment of intrauterine pathology: ACOG Committee Opinion Summary, Number 800. Obstet Gynecol. 2020;135(3):754-756. doi: 10.1097/ACOG.0000000000003713.

Additional relevant publications and studies that may be of interest include:

- Angioni S, Loddo A, Milano F, Piras B, Minerba L, Melis GB. Detection of benign intracavitary lesions in postmenopausal women with abnormal uterine bleeding: a prospective comparative study on outpatient hysteroscopy and blind biopsy. J Minim Invasive Gynecol. 2008;15:87-91.
- Grimbizis GF, Tsolakidis D, Mikos T, et al. A prospective comparison of transvaginal ultrasound and saline infusion sonohysterography and diagnostic hysteroscopy in the evaluation of endometrial pathology. Fertil Steril. 2016;94(7):2720-2725.
- Maheux-Lacroix S, Li F, Laberge PY, Abbott J. Imaging for polyps and leiomyomas in women with abnormal uterine bleeding. Obstet Gynecol. 2016;128(6):1425-1436.
- Moawad N, Santamaria E, Johnson M, Shuster J. Cost effectiveness of office hysteroscopy for abnormal bleeding. JSLS. 2014;18:1-5.
- The use of hysteroscopy for the diagnosis and treatment of intrauterine pathology: ACOG Committee Opinion Summary, Number 800. Obstet Gynecol. 2020;135(3):754-756. Doi 10.1097/ACOG.0000000000003713.
- Goldstein SR. Finding a better approach to diagnosing abnormal uterine bleeding. OBG management. (suppl) Nov 2016.

Kris Davis
EVEXIAS Medical Centers/ Denver Vein Center

On July 1, 2023, the attached Fee Schedule was posted by Health First Colorado. Based on this fee schedule, we opted to treat several vein patients with Varithena (CPT Code 36466). We had only recently begun offering it as a service, and avoided offering to Health First Patients because the reimbursement previously would not even cover the cost of the medication. After seeing the reimbursement went up, allowing us to cover our facility costs, medication costs and staff costs, we sought authorization and then saw two patients in our office.

We were stunned when reimbursement came in for the treatment at $88. We logged on again and saw that Health First had changed the reimbursement back to the lower price. As a small business, with only one provider who focuses solely on Varicose Veins, this was disappointing to say the least. We've seen great results for the patient, but unfortunately, due to the low reimbursement, we are not able to offer Health First patients any more treatment. The patients are as disappointed as we are.

We would like an explanation as to why Health First Colorado (who only publishes changes to their fee schedule twice a year in January and July) decided to revert back after clearly publishing a higher rate. It feels a bit like a bait and switch and very unethical.

We are asking that you honor the pricing that was posted and reprocess the following claims.
7/26/23 2223278004733
8/10/23 2223271010531

Respiratory System Surgeries

No public comment.

Integumentary System Surgeries

No public comment.

Eye and Auditory System Surgeries

No public comment.

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Other Surgeries

No public comment.

Other Feedback

Viral Kothari, MD
Board Certified in Pediatrics, Pediatric Pulmonology and Sleep Medicine
Pediatric Pulmonary & Sleep Specialists

I wanted to reach out to you to introduce myself, and let you know about my practice. I actually began working with HCPF in 2018 originally with the assistance of Kim Bimestefer and Parrish Steinbrecher. I've heard great things about you and am glad to learn that you are the Fee for Service and Rates Manager. I am reaching out to you directly instead of the generic inbox that Trevor provided me with due to the dire circumstances that the low Medicaid reimbursement for non-facility pediatric sleep study codes is putting us in and because my request requires review from someone at your level.

I'm a triple-boarded pediatric sleep specialist. Currently, children needing sleep services in Colorado have two options: my practice and Children's Hospital. We provide the exact the same service (in our office) as Children's Hospital, using the same costly monitoring equipment (including continuous CO2 monitoring), are subject to the same expensive rent due to locating on or near a hospital campus for patient safety reasons, compete for the same expensive staff due to the additional staffing attention required by registered sleep technologists to care for children, and employ the same highly specialized physician staff required to direct care for these medically complex patients. The difference is that Children's Hospital submits two claims (including a facility bill) and as a result gets paid a few hundred dollars more per test for the exact same service! You can only imagine how undervaluing our program like this hurts our ability to care for Medicaid insureds.

When our services are not available, there are significant wait times (> 6-12 months) to get into the Children's Hospital sleep center. Due to this, patients who DO NOT need their tonsils and adenoids removed are having them removed in an effort to "try" to help them sleep better. Having unnecessary invasive surgery is an unsafe practice and very costly for Colorado Medicaid. I have included the surgical codes below for your finance team to review. It's my understanding that the OPPS rates for these codes are more than $4,000 excluding the surgeon's professional fee. Tricare is really driven by this fact when considering my rate request. They said that they are interested in my sleep medicine practice being in their network because they want to avoid the current expense of unnecessary Tonsillectomy and Adenoidectomy procedures. They'd rather pay for a comprehensive sleep assessment than spend millions of dollars annually for potentially unnecessary pediatric upper airway major surgeries. Please consider that most T&A surgeries are avoided by referral to us. By valuing our place in the market, Medicaid will save millions of dollars on unnecessary T&A surgeries.

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42820	Remove tonsils and adenoids, younger than 12
42821	Remove tonsils and adenoids, age 12+
42825	Removal of tonsils, primary or secondary, younger than 12
42826	Removal of tonsils, primary or secondary, age 12 or over
42830	Removal of adenoids
42831	Removal of adenoids
42835	Removal of adenoids
42836	Removal of adenoids

In addition to avoiding surgical costs, patients treated correctly for sleep issues also avoid becoming chronic prescription medication users for common scripts like ADHD and depression medications. These treat the symptoms of poor sleep, not the underlying issues.
I am the only private practice option for Colorado Medicaid, and the only provider who performs pediatric sleep studies in my office.
For parity, we are asking for our in-office claims for the 4 sleep study codes to be reimbursed at the same rate as Children's Hospital. This will allow me to remain as an independent provider.

For Colorado Medicaid, you remain less reliant on the monopoly of Children's, and have a local alternative for your insureds (preventing them the inconvenience of driving for several hours to Aurora with their, by definition, chronically-ill children) to have their sleep study performed. Further, Children's is much more inclined to perform surgeries on children who receive their sleep studies there. With my specialization in pulmonology, I'm able to assess the critical nature of the condition, and am comfortable suggesting alternatives to surgery, and work in close collaboration with the pediatric ENTs and pediatric Neurosurgeons, as required, for the least invasive (read: less expensive for Colorado Medicaid) patient management, if any is required.

We'd like to be reimbursed the same as Children's Hospital, their rates are in the below table.

CPT Code	Requested reimbursement
95782	$1061.64
95783	
95810	
95811	

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If this increase cannot be limited to me by virtue of the fact that I'll be the only physician in Colorado billing these in a non-facility setting, then perhaps we can look at using a HCPCS T-code (T1000-T5999), which are exclusively for the use of Medicaid payors. At a quick glance, there are T-codes which could accommodate this narrow fee schedule request for these 4 sleep studies.

Thank you so much for reaching out to me, Lingling. I was actually planning to check in with you all this week for an update and to discuss the approach that I believe we should take. I think this approach would solve the issue related to the delayed cyclical review. As I mentioned before, we'd like to be reimbursed the same as Children's Hospital, their rates are in the below table.

CPT Code	Requested reimbursement
95782	$1061.64
95783	
95810	
95811	

I feel the best way to accomplish this would be by using a HCPCS T-code (T1000-T5999), which are exclusively for the use of Medicaid payors. As mentioned previously, there are T-codes which could accommodate this narrow fee schedule request for these 4 sleep studies.

Please let me know when we can jump on a call to discuss this further.

Kevin and I connected on August 21st. I understand you all have a lot going on currently so I would like to simplify my request with key bullet points:

- **We are not asking the state to increase their budget to accommodate our request.** This is due to the fact that the only service providers for pediatric sleep medicine services are us and Children's Hospital (CHCO).
    - One easy way to prove that we and CHCO are the primary service providers for children is by looking at all of your 95782 claims. You will see that the vast majority of the claims are from us and CHCO.
- We are being asked to be reimbursed for 95782, 95783, 95810 and 95811 at the same rate that they are being reimbursed when you add their facility fee and physician together (in the table below). **Taking this approach would not require a budgetary approval because you are already paying the other service provider, CHCO, the requested rates.**

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CPT Code	Requested reimbursement
95782	$1061.64
95783	
95810	
95811	

I feel the best way to accomplish this would be by using a HCPCS T-code (T1000-T5999), which are exclusively for the use of Medicaid payors. As mentioned previously, there are T-codes which could accommodate this narrow fee schedule request for these 4 sleep studies.
Please let me know when we can jump on a call to discuss this further.

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Appendix E – Glossary & County Reference Map

Appendix E provides explanations for common terms used throughout the 2021 Medicaid Provider Rate Review Analysis Report, as well as a reference map of counties in Colorado by classification.

Active Provider - Any provider who billed Medicaid at least once between March 2017 and December 2019 for one of the procedure codes under review.

Benchmark Rates - Rates to which Colorado Medicaid rates are compared.

Billing Provider - Based on the billing provider ID, which is generally associated with the entity enrolled with Medicaid. This can be agencies, large provider groups, or individuals.

Colorado Repriced – This amount represents the application of current Colorado Medicaid rates (FY 2018-19) to the most recent and complete Colorado utilization data, obtained from claims data.

Comparison Repriced – This amount represents the application of comparators' most recently- available fee schedule rates to the most recent and complete Colorado utilization data, obtained from claims data.

County Classification – Three regional descriptors applied to counties by the Regional Accountable Entities (RAEs).

Distinct Utilizers – The total number of distinct members who utilized a service.

Drive Time - Measures the percent of Colorado Medicaid members who traveled within four drive time bands (e.g., 0-30 minutes, 30-45 minutes, 45-60 minutes, over an hour) to receive services.

Member-to-Provider Ratio - The number of total Medicaid members per active rendering provider within a geographic area; calculated as providers per 1,000 members. It allows for comparison across areas with large differences in population size.

Panel Size Estimate - The average number of clients seen per rendering provider.

[1] County classifications are defined as the following: urban counties are any county in the contractor's service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor's service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor's service area with a population density less than or equal to 6 persons per square mile.

Penetration Rate - The total share of enrolled Colorado Medicaid members who utilized a service; calculated per 1,000 members.

Provider Count - A distinct count of the number of providers who billed for the service. Whether the provider is a billing provider or rendering provider is identified in the report.

Rate Benchmark Comparison – This percentage represents how Colorado Medicaid payments compare to other payers. It is calculated by dividing the Colorado Repriced amount by the Comparison Repriced amount.

Rate Ratio - For each service code, and relevant modifier, the rate ratio is the division of the corresponding Colorado rate to the Benchmark Rate. For example, if procedure code 99217 has a Colorado Medicaid rate of $56.08 and Medicare has a rate of $73.94 then the resulting rate ratio is $56.08/$73.94 = 0.7585, expressed as a percentage as 75.85%.

Rendering Provider - The provider who rendered, or directly provided, the service.

Total Members – The total number of enrolled Colorado Medicaid members.

Units - Quantities associated with a procedure; they may vary depending on type of service. The most common unit is one and represents the delivery of one unit of a service. Other services, such as physician- administered drugs, have a denomination reflected by the drug dosage (e.g., 1 mL, 5 mL, etc.). Some therapy and radiology services define units by time (e.g., 15 minutes). Not all payers share the same unit definitions and adjustments are sometimes incorporated to account for payer differences.

Utilizer Density - The number of distinct utilizers of a service in each county.

Utilizers per Provider – The average number of members seen per active provider, also called Panel Size.

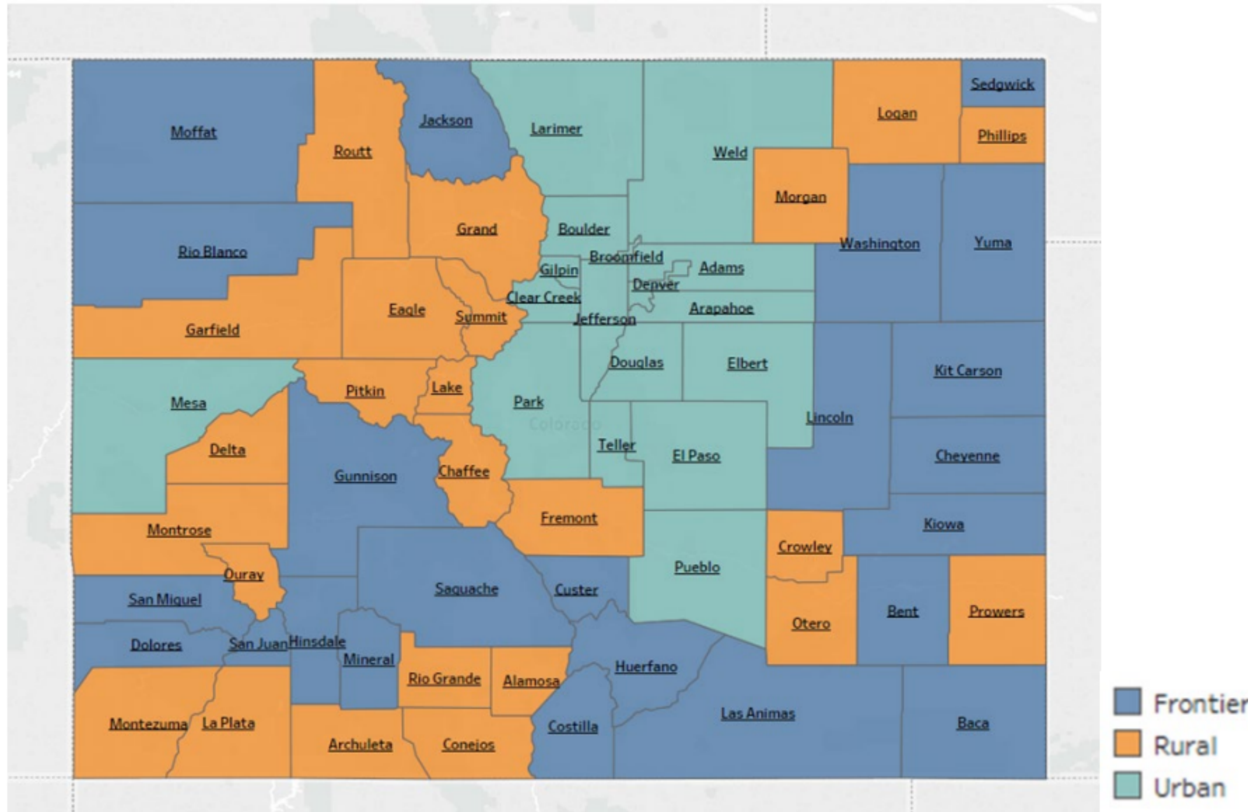

Figure 1. Colorado counties and RAE county classifications.

RAE County Classification					
Urban		Rural		Frontier	
Adams	Mesa	Alamosa	Logan	Baca	Las Animas
Arapahoe	Park	Archuleta	Montezuma	Bent	Lincoln
Broomfield	Pueblo	Chaffe	Montrose	Cheyenne	Mineral
Boulder	Teller	Conejos	Morgan	Costilla	Moffat
Clear Creek	Weld	Crowley	Otero	Custer	Rio Blanco
Denver		Eagle	Ouray	Dolores	Saguache
Douglas		Delta	Phillips	Gunnison	San Juan
Elbert		Fremont	Pitkin	Hinsdale	San Miguel
El Paso		Garfield	Prowers	Huerfano	Sedgwick
Gilpin		Grand	Rio Grande	Jackson	Washington
Jefferson		Lake	Routt	Kiowa	Yuma
Larimer		La Plata	Summit	Kit Carson	

Table 1. Colorado counties by RAE county classification.

[1] County classifications are defined as the following: urban counties are any county in the contractor's service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor's service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor's service area with a population density less than or equal to 6 persons per square mile.