ACCESS MONITORING REVIEW PLAN 2019
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Executive Summary

The Colorado Department of Health Care Policy & Financing (the Department) administers the State’s public health insurance programs, including Health First Colorado (Colorado’s Medicaid Program - Colorado Medicaid is used in place of Health First Colorado in this Plan to maintain consistency with the Centers for Medicare and Medicaid Services (CMS) and Colorado Health Access Survey (CHAS) reporting), and Child Health Plan Plus (CHP+), as well as a variety of other programs for eligible Coloradans. The Department’s mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Colorado Medicaid members include children, pregnant women, people with disabilities, the elderly and aging, parents, and adults ranging in age from 19 to 64. During calendar year 2018, more than 1.15 million Coloradans were enrolled in Colorado Medicaid. Most Colorado Medicaid members are not on the program for long periods of time; however, some have lifelong conditions that require long-term enrollment.

In October 2015 CMS issued the final rule Methods for Assuring Access to Covered Medicaid Services (CMS-2328-FC), establishing a process for ongoing analysis and monitoring of Medicaid members’ access to medical assistance, as is required under section 1902(a)(30)(A) of the Social Security Act. The Department prepared its first report under this regulation in 2016.

For the 2019 Access Monitoring Review Plans, CMS partnered with Mathematica to develop a reporting toolkit to reduce the administrative burden on state departments and to ensure consistency in measuring. CMS guidance is that this toolkit can form the full reporting for a state to meet the requirements of CMS-2328-FC. The toolkit comprises ten templates with prescribed data entry formats. States have some flexibility in defining what constitutes a provider type and reporting levels (e.g. county, state-wide, HSR etc.); however, the entry of data is restricted to the questions developed by Mathematica.

The Department completed the templates in the reporting toolkit (see Appendices A, E-F, I-M). It prepared this Access Monitoring Review Plan (the Plan) to:

- Further explain and explore, within the parameters of 42 CFR 447.203, how Colorado Medicaid member access compares to other Coloradans, and
- Provide a more complete picture of access for Health First Colorado Members.

We are committed to working with stakeholders to evaluate and improve access to care and believe that this additional narrative, which explains the information in the toolkit and brings
in additional data services, will allow readers to better understand the picture of access for Colorado Medicaid Members.

The 2019 Plan includes an analysis of the data points below and the Department’s conclusion of the sufficiency of access to care as defined in 42 CFR 447.203. It will be used to inform state policies affecting Colorado Medicaid services. The Plan includes analysis of administrative data, provider enrollment data, health access survey data, and rate comparison data.

The Plan analyzes the following service categories delivered under a fee-for-service arrangement:

- Primary Care Services,
- Physician Specialist Services,
- Behavioral Health Services,
- Pre- and Post-natal Obstetric Services (including labor and delivery),
- Home Health Services.

The Plan considers the following:

- the extent to which member needs are met;
- the availability of care through enrolled providers to members in each geographic area, by provider type and site of service;
- changes in member utilization of covered services in each geographic area;
- the characteristics of the member population (including considerations for care, service, and payment variations for pediatric and adult populations and for individuals with disabilities); and
- actual or estimated levels of provider payment available from other payers, including other public payers, by provider type and site of service.

To supplement the Plan and provide further information for stakeholders, the Department has prepared seven regional fact sheets which outline the access findings for each region, including comparisons with other Coloradans in the same geographic area (see Appendix C – Regional Fact Sheets).

Note: the analysis herein does not constitute the entirety of the Department’s work to evaluate and impact member access to services. For example, it is limited to the specific service groupings above, and, where it is possible to compare access across regions (e.g. for primary care and specialty care services) determinations of access sufficiency are based on whether access is similar to that of other Coloradans in the same geographic region, as is required by the regulation.
Measuring access to care for Medicaid members is complex. There is no single measure for evaluating access, and no one report can fully capture the picture of Colorado Medicaid member access to care. This Plan is not a definitive report on Colorado Medicaid member access to services; it captures a limited and prescribed data set for a specific purpose.

While CMS has access reporting guidelines, these do not fully reflect the Department’s commitment to measuring and improving access for Colorado Medicaid members. The Department wants Colorado Medicaid members to be able to access health care at the right time, the right place, and in the right setting. The Department also wants to hold providers accountable for providing access to clinically and culturally appropriate care for Colorado Medicaid members.

The Department is working on numerous efforts to monitor and improve member access. The Department is working with the Colorado Department of Public Health and Environment (CDPHE) to utilize their evolving provider repository to more accurately measures provider availability to Medicaid members. The goal of this partnership is to improve provider access by querying the number of available providers by specialty and county; a subset of the number of enrolled Medicaid providers; and a further subset of the number of those providers who are actually seeing a meaningful volume of Medicaid patients. Initial data from this tool is included in the Behavioral Health and Primary Care sections of this report. The Department hopes to have this work completed by the end of Q1 2019-2020.

The Department plans to work with stakeholders on what improvements can be made to increase the number of providers who are readily available to see Medicaid patients. The Department also plans to work with stakeholders, providers, and other government agencies on aligning goals around access and provider availability.

Other Departmental initiatives include the production of new reports and expansion of existing reports that measure factors that should be considered when evaluating and improving provider access, such as:

- A new Medicaid Churn analysis, which measures how frequently members are leaving and reentering Medicaid.
- Colorado Health Institute (CHI) provision of the biennial Colorado Health Access Survey (CHAS), which provides information and insights into the uninsured population in Colorado. Medicaid Cliff Effect insights, which considers how the cliff effect\(^1\) is impacting member enrollment levels.

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A *benefits cliff* is what happens when public benefit programs, such as Medicaid, taper off or phase out quickly when household earnings increase. The abrupt reduction or loss of benefits can be very disruptive for families because even though *household earnings increased*, they usually have not increased enough for self-sufficiency. The steep reduction in benefits can discourage people from engaging in workforce development programs or from seeking employment.
Plan Conclusions

Data indicates that, between January 2016 and December 2018, the number of providers serving Colorado Medicaid members remained fairly constant across service categories while the number of members accessing services increased. In most regions, and for all but one service category, the number of utilizers and active providers was either trending steady or trending up. Pre- and post-natal obstetric service utilization and active service providers decreased; however, this appears to be in line with the national trend of decreasing birth rates rather than an inability of members to access services.

Data indicates that the vast majority of members have potential access\(^2\) to services within 0-30 minutes driving time; a minimum of 96% of all Colorado Medicaid members live within a 30-minute drive to all service category providers. This number increases to 99.4% for primary care. The Department is currently working on improving its data capabilities for future reports to also measure realized access, e.g. where members actually received services in relation to their residence. This will allow the Department to better understand where members are receiving services and what reasons may be affecting why they are travelling further than the closest available provider. In complement to the above project work, it will also allow the Department to identify providers who are enrolled but may not be accepting patients, and to work with them on addressing the barriers to accepting Colorado Medicaid members as patients.

While, in aggregate, access to care appears to be sufficient for all five service categories, as defined in 42 CFR 447.203, the Department continues to conduct ongoing analysis into specific procedures, provider types, demographic groups and geographic locations as part of its larger, ongoing access evaluation efforts, as noted above.

\**In 2017, 81% of Medicaid clients surveyed said their family’s needs were being met by the health care system, higher than any insurance type, including employer-sponsored insurance\(^3\).**

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\(^2\) Potential access is defined as the potential for members to access needed health care and measures whether the infrastructure and providers exist to ensure people can get the care they need.

Ongoing Department Efforts to Evaluate Access to Care

Evaluating Access to Care

What is Access to Care?

For the Department, access to care is the consideration of whether Colorado Medicaid members have meaningful access to needed health care services.

There is no single, uniform, nationally accepted definition of access or access to care, nor a set standard or threshold for what is considered sufficient or optimal access to care. However, a determination of whether access is sufficient generally involves determining the extent to which people can access:

- the right health services,
- at the right time,
- in the right setting,
- for the right duration.

What is the Department’s vision for its access-to-care work?

The Department, in a timely and transparent manner:
- conducts ongoing and appropriate access evaluation;
- develops evidence-based recommendations; and
- implements actionable solutions to improve access.

What does the Department consider when looking at health care access?

The Department generally evaluates access across population groups, regions and services. When doing so, the Department usually evaluates the five basic A’s of access:

- **Affordability** – Is the member willing and able to pay for the required services? This includes things like co pays as well as incidental costs such as transportation, childcare, etc.
- **Availability** - Is the member able to see a provider in a timely manner?
- **Accessibility** - Is the member able to see a provider within a reasonable distance from their home?
- **Accommodation** – Are members able to access services in a manner that suites them? For example, do providers have hours outside of standard business hours or on weekends.

**The What:**
Can members access necessary care, at the appropriate time, and in the appropriate setting?

**Questions We Ask:**
Is care available, accessible, and acceptable?
• **Acceptability** - Do members have access to acceptable care? For example, care that is free of judgement or discrimination?

How does the Department conduct an access analysis?

The Department conducts access analysis in a variety of ways depending on the focus of the inquiry. Analysis generally includes a quantitative analysis of both internal and external data sources. This could include analysis of member to provider ratios, service utilization, wait times, driving distances and other quantitative measures.

Qualitative analysis may include surveying members and providers, reviewing member complaints, and engaging with stakeholders to further understand potential issues.

The Department also partners with other organizations involved in similar work, such as the Colorado Health Institute, to gather additional data.

**Departmental Initiatives**

The Department has introduced a number of initiatives that aim to explore and improve Colorado Medicaid member access to care. This includes new reports which look at issues impacting member access such as churn rates and the cliff effect.

It also includes work with other government agencies such as the Colorado Department of Public Health & Environment on improving how provider enrollment and activity is measured and tracked, to ensure that enrolled providers are actually seeing Colorado Medicaid members.

**State Regulations**

In 2015, the Colorado State Legislature adopted Senate Bill 15-228, requiring the Department to establish a formal rate review process. As part of this requirement, the Department created a five-year schedule to review rates not subject to already-established review processes. The Department also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC), which assists the Department in the review of provider rate reimbursements. The Rate Review process augments the Department’s existing rate setting process.

The MPRRAC consists of 24 members appointed by members of the Colorado State Senate and House of Representatives. MPRRAC members represent 24 different areas of health care and work together to inform the Rate Review process, while also providing expertise as
needed. The MPRRAC assists the Department in the review of provider rate reimbursements by:

- conducting public meetings with the Department;
- reviewing the Analysis Reports;
- providing recommendations to the Department;
- reviewing stakeholder proposals for provider rates to be reviewed or adjusted; and
- amending the Rate Review schedule as needed.

The Rate Review process provides opportunities for significant stakeholder engagement. Stakeholders can:

- attend data sessions to gain a better understanding of, and comment on, data as it relates to service utilization, access, and quality;
- attend MPRRAC meetings and provide feedback, including recommendations, related to the meeting agenda and discussions during the public comment portion; and
- submit a proposal for provider rates to be reviewed or adjusted.

The Department compares a broader set of rates over its five-year schedule than included in this Plan’s comparison. The Rate Review process has established a methodology that better captures differences between payers, including how to compare code modifiers, and compares with a larger grouping of payers (up to 11 different states compared to three in this Plan).

Through the Rate Review process the Department prepares a recommendation report and an analysis report annually for the legislature on the services reviewed that year. Past reports can be found at the Department’s MPRRAC site.

**Federal Regulations**

In October 2015 the Centers for Medicare and Medicaid Services (CMS) issued the final rule Methods for Assuring Access to Covered Medicaid Services (CMS-2328-FC), establishing a process for ongoing analysis and monitoring of Medicaid members’ access to medical assistance, as is required under section 1902(a)(30)(A) of the Social Security Act. This Plan satisfies the requirements of the regulation.

Note: the analysis herein does not include many of the metrics listed above that the Department usually evaluates when investigating a specific access issue, and it does not constitute the entirety of the Department’s work to evaluate and impact member access to services. For example, this Plan is limited to specific service groupings, and, where it is possible to compare access across regions (e.g. for primary care and specialty care services), determinations of access sufficiency are not based on the five access dimensions listed above, rather, they are based on whether access is similar to that of other Coloradans in the
same geographic region, as is required by the regulation. Measuring access to care for Medicaid members is complex. There is no single measure for evaluating access, and no one report can fully capture the picture of Colorado Medicaid member access to care. This Plan is not a definitive report on Colorado Medicaid member access to services; it captures a limited and prescribed data set for a specific purpose.
Medicaid Managed Care

The Department is committed to creating a high-performing, cost-effective Medicaid system that delivers quality services and improves the health of Coloradans.

Launched in 2011, the Accountable Care Collaborative is the primary vehicle for delivering health care to nearly one million Colorado Medicaid members. The program works on the principle that coordinated care, with needed community supports, is the best way to deliver care, especially to those with complicated health needs.

In Phase I of the Accountable Care Collaborative, which concluded 30 June 2018, the Department contracted with seven Regional Care Coordination Organizations (RCCOs) to assist with:

- connecting members to primary care services;
- making the system more user friendly for members and providers;
- coordinating medical and non-medical services for members with complex needs; and
- using data to inform decision-making.

In Phase I, the program grew from serving 500 members to serving about one million members. Under this managed care structure, RCCOs were paid a per member per month fee to increase care coordination, improve the delivery of primary care, and connect more Coloradans to a medical home to prevent and manage illness. Providers within the RCCO network continued to bill the Department for medical services rendered on a fee-for-service basis.

On 1 July 2018, the Department launched Phase II of the Accountable Care Collaborative (ACC) with the goal of improving Colorado Medicaid members’ health and reducing costs. The ACC model aims to improve access for members by coordinating care and linking every member with a Primary Care Medical Provider.

Most full-benefit Colorado Medicaid members are now mandatorily enrolled in the ACC and immediately connected with a Primary Care Medical Provider (PCMP). The Department now has contracts with seven Regional Accountable Entities (RAEs), which are accountable for coordinating both physical and behavioral health for its enrolled members. Providers in the RAE network continue to bill the Department for medical services rendered but bill the RAE directly for behavioral health services rendered.  

\[4\] Very few behavioral health services are reimbursed outside the capitated managed care network (e.g. fee-for-service).
RAEs are responsible for:

- developing a network of PCMPs to serve as medical home providers for their members;
- developing a statewide network of contracted behavioral health providers;
- administering the Department’s capitated behavioral health benefit;
- onboarding and activating members;
- promoting the enrolled population’s health and functioning; and
- coordinating care across disparate providers, social, educational, justice, and other community agencies to address complex member needs that span multiple agencies and jurisdictions.

The Department also contracts with two capitated medical managed care networks (Denver Health and Rocky Mountain Health Plan Prime) based in Denver and the counties of Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco, respectively. The medical services rendered within these two networks are outside the purview of this Plan, as are the capitated behavioral health services rendered through the RAEs.

While these services are outside the scope of this Plan, the Department has a robust system in place for monitoring services managed by the RAEs and capitated medical managed care networks. The Department requires RAEs to submit quarterly Provider Network Adequacy reports. The Quarterly Network Report is one method for monitoring RAE provider networks and compliance with the RAE’s approved Network Adequacy Plan. The Department uses the reported information for a variety of purposes, such as:

- Monitoring access in rural and frontier areas and identifying what steps RAEs are using to mitigate challenges;
- Reporting how many providers take new members; and
- Assessing client to provider ratios.

RAEs report on network sufficiency, any deficiencies identified during the reporting period, and any remedial action taken to address these. RAEs report on both primary care and behavioral health access and adequacy. The two capitated medical managed care networks also prepare and report quarterly on network adequacy plans.
Ensuring and Improving Access to Care in Colorado

The Department is committed to ensuring Colorado Medicaid members can access the right health services, at the right time, in the right setting, for the right duration. Since publication of the 2016 Access Monitoring Review Plan, the Department has invested significant time and resources into conducting population, regional, and service specific access analyses. The Department is committed to conducting ongoing and appropriate access evaluations, developing evidence-based recommendations, and implementing actionable solutions, in a timely and transparent manner.

Our Vision

Health First Colorado members can access: the right health services; at the right time; in the right setting, for the right duration.

During the most recent reporting period, from 1 January 2016 through to 31 December 2018, the Department achieved access-to-care improvements through its existing efforts and through new initiatives.

Did you know?

- In 2016, the Department convened stakeholders to ensure coverage policy was appropriate to meet the needs of transgender members.
- The Department is now working with community partners to evaluate Health First Colorado LGBTQ+ member access to care.

Transgender Benefits

In 2016, the Department initiated a Benefits Collaborative process to codify coverage policy related to gender transition services. As part of this effort, the Department worked to remove unnecessary policy barriers to accessing appropriate care. For example, the Department lowered the age (to 16) at which Colorado Medicaid members can access puberty suppressing hormone therapy.

The transgender benefit is a leading example of coverage in the nation. One Colorado, in a recent public launch for their 2019 Closing the Gap report, indicated it would like to use the policy as a template for improving commercial coverage in the State.
Home & Community-Based Waiver (HCBS) Services
In 2017 the Department evaluated, through its Rate Review process, whether provider reimbursement rates were sufficient to ensure member access to Home and Community-Based Waiver (HCBS) services.

As part of the process, the Department convened a Medicaid Provider Rate Review Advisory Committee (MPRRAC) meeting at which more than 50 stakeholders provided feedback on analysis findings and current access issues.\(^5\)

As a result, the Department recommended to the legislature that additional funding be allotted to close the gap between current HCBS reimbursement rates and the cost of providing services. Special attention was paid to those services identified by stakeholders as most in need of improved rates.

In 2017, the Department received $15.7 million to increase rates for assisted living residences for the elderly and people with disabilities. In 2019, the Department received an additional $10.2 million to increase rates for other high-value HCBS waiver services. For example, the Department received approval to eliminate entirely the budget neutrality factor for respite care, transition services, and behavioral health counseling.

Did you know?
In 2017, the Department engaged 50+ HCBS stakeholders through the Rate Review process regarding their access concerns and recommended further funding for HCBS services to improve access.

Did you know?
In 2018, the Department:
• Evaluated whether provider reimbursement rates were sufficient to ensure member access to maternity services.
• Secured an additional $4 million in funding to increase provider reimbursement rates.

Maternity Services
As of 2016, approximately 45% of babies born in Colorado were born to mothers enrolled in the Colorado Medicaid program (including CHP+).

In 2018, the Department evaluated, through its Rate Review process, whether provider reimbursement rates were sufficient to ensure member access to maternity services and recommended an increase to maternity rate services.

\(^5\) For example, the review identified that Alternative Care Facilities (ACF) rates were well below comparative rates in other states. Stakeholders provided considerable feedback that current rates were not sufficient to cover increased costs associated with facility maintenance, property taxes, minimum wage increases and new regulatory requirements.
As a result, the Department secured $4 million in additional funding for maternity services in the most recent budget cycle. The Department also investigating value- and quality-based payment models that may further improve access to, and quality of maternal health care for, Colorado Medicaid members.

Durable Medical Equipment
On January 1, 2018, the Center for Medicare and Medicaid Services (CMS) introduced upper payment limits (i.e. caps on how much the department can pay) for certain Durable Medical Equipment (DME) services. The Department received feedback from supplier stakeholders that this new payment rate was impacting their ability to service Medicaid members.

In response, the Department conducted several surveys of suppliers, provider clinics, and hospitals, and reviewed claims analyses, to determine whether and to what extent front line providers were experiencing new access barriers. While initial results indicated members were still able to access services, an ongoing process was established to evaluate and track how access is impacted over time, with special attention to select DME services such as Oxygen Therapy, Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BIPAP) machines, Ventilators, and Pediatric Nebulizers.

The Department chose to include a review of DME services subject to upper payment limits in this year’s Rate Review process, to further evaluate access and align efforts across Departmental evaluation initiatives. Findings of this process will be included in the 2019 Rate Review Analysis Report.

Transportation

In late 2018 the Department’s transportation broker began a phased rollout of Special Discount Cards (SDCs) to eligible members in the Denver-area, based on their age or disability.

Previously, individuals were required to physically go to Regional Transportation District (RTD) offices to get a pass and provide medical documentation to support a disability claim. This involved a visit to their doctor to complete a required disability form.
This change:

- Allows the broker to issue SDCs, without medical documentation, if a member is enrolled in a Home and Community Benefit Services (HCBS) waiver. RTD now accepts the Department’s determination as proof of a disability. This means that a member does not have to go to the doctor to get another form completed.
- Allows the broker to issue SDCs to eligible members via mail, eliminating the required travel to RTD’s office for members already having transportation barriers.
- Allows members to use their SDC to receive the discount on trips that do not qualify as Non-Emergent Medical Transportation or Non-Medical Transportation., Ultimately this saves members’ money for other uses.

The Department also worked with RTD in 2018 to introduce day passes for members. Day passes are the same price as two one-way tickets, which the Department previously reimbursed to and from a medical service. A day pass allows a member to access transportation all day (prior to and after their medical appointment) at no additional cost to the Department.

**Did you know?**

In 2018, the Department:

- Worked with its Transportation broker and the local public transportation provider (RTD) to address transportation barriers faced by members
- Streamlined application processes for member transportation discount cards
- Changed its contract with RTD to provide members with greater flexibility and all-day public transportation access.
Plan Format, Data, and Methodology

Plan Format

This Plan considers access to care across five broad service categories: Primary Care Services; Physician Specialist Services; Behavioral Health Services; Pre- and Post-natal Obstetric Services; and Home Health Services.

Within each category the Department’s analysis of access considers the following:

- Characteristics of the Member Population, which includes total utilizer counts and demographics;
- Utilization Analysis\(^7\), including:
  - Total Utilizer Count;
  - Total Active Billing Provider Count - providers are considered ‘active’ if they are enrolled as a Medicaid provider and have submitted a claim for payment in the calendar year; and
  - Service Penetration Rate - the number of members utilizing a service as a percentage of the total eligible FFS Colorado Medicaid population.
- Colorado Health Access Survey Data (for Primary Care and Physician Specialist Services);
- Health Professional Shortage Areas (for Primary Care and Behavioral Health Services);
- Drive Time Mapping across the state for all service categories except home health (where services are delivered in the home and members do not have to travel);
- Rate Comparison;
- Input from Beneficiaries, Providers, and Stakeholders;
- Additional Access Analysis Identified as a Result of this Review;
- Extent to Which Member Needs are Fully Met.

\(^6\) Fulfills requirements 42 CFR 447.203(b)(1), 42 CFR 447.203(b)(1)(i) through (v), 42 CFR 447.203(b)(4)

\(^7\) While this information is useful for understanding differences in utilization across services and regions, and over time, it must be analyzed in combination with other statistics to make a determination of access sufficiency.
Health Statistics Regions

The Colorado Department of Public Health and Environment (CDPHE) has grouped Colorado’s 64 counties into 21 Health Statistic Regions (HSRs) for public health planning. These 21 HSRs were developed by the Health Statistics and Evaluation Branch of CDPHE in partnership with state and local health professionals. HSRs were developed using statistical, demographic, and survey data criteria. HSRs group together counties in which the population coalesces to access health care. Medicaid member population counts within various HSRs vary widely depending on the geographic region. See Figure 1 for a map of all HSRs.

In this Plan, the HSRs are further grouped into seven regions for geographic health care access analysis. See Figure 2 for a map of the seven regions, which include:

- Eastern Plains region (HSRs 1, 5 & 6)
- Northwestern Colorado region (HSRs 11, 12 & 19)
- Colorado Springs/Pueblo region (HSRs 4, 7 & 13)
- San Luis Valley region (HSRs 8, 9 & 10)
- Northern Colorado region (HSRs 2, 16 & 18)
- Metro Denver (North & East) region (HSRs 14, 15 & 20)
- Metro Denver (West & South) region (HSRs 3, 17 & 21)

An Access to Care Fact Sheet for each region outlining findings for each of the five service categories, can be found at Appendix C – Regional Fact Sheets.

County level and individual HSR level data is not used in this report because the sample sizes can often be too small for inclusion in analysis per the Department’s guidelines for suppressing all data samples below 30. This to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations and to prevent potential identification of individual members. Table 2 crosswalks each of the 64 counties to their respective HSR.
<table>
<thead>
<tr>
<th>County</th>
<th>HSR #</th>
<th>Region</th>
<th>County</th>
<th>HSR #</th>
<th>Region</th>
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<td>Arapahoe</td>
<td>15</td>
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<td>San Luis Valley</td>
<td>Park</td>
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<td>Jefferson</td>
<td>21</td>
<td>Metro Denver (West &amp; South)</td>
</tr>
</tbody>
</table>

Table 1 – County/HSR Crosswalk
Figure 1 – Map of Colorado Health Statistics Regions (HSR)

Figure 2 – Map of Colorado Health Statistics Regions (HSR) Groupings
Access Analysis Data Sources

Data for the access review contained within this Plan comes from five primary sources:

- For data from January 2016 to March 2017:
  - Administrative claims within the legacy Xerox Medicaid Management Information System (MMIS), stored in the legacy Xerox Decision Support System (DSS) data warehouse;
- For data from April 2017 to December 2018:
  - Administrative claims adjudicated by the interChange system, Colorado’s new MMIS, as stored in Colorado’s Business Intelligence and Data Management (BIDM) system;
- The 2013, 2015, and 2017 Colorado Health Access Surveys, conducted by the Colorado Health Institute (CHI); and
- Rate comparison data from Medicare, the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid.
- Stakeholder input.

Access Analysis Methodologies & Assumptions

Administrative Data

The following administrative data is included in the Plan.

- Total Utilizer Count - stratified by HSR grouping. This metric depicts whether the number of service utilizers increased or decreased in each geographic region over the three-year reporting period. Trends are examined in monthly increments, for calendar years 2016, 2017 and 2018. Note: an upward or downward trend in the metric, taken alone, does not indicate improvement on the metric; a decrease may signal that members no longer require the service due to positive health outcomes, and an increase may signal that provider availability has improved and more members are able to access services.

Figure 3 – Sample Utilizer Count Graph
• Total Active Billing Provider Count - stratified by HSR grouping. Active providers are those providers enrolled with Medicaid who have submitted a claim within the past calendar year. This metric depicts whether the number of active service providers increased or decreased in each geographic region over the three-year reporting period. The Department employed a hierarchical data analysis whereby if a rendering provider existed on the claim they were counted, and if not, the billing provider was counted. Trends are examined on a yearly basis, with active status captured on 31 December of each calendar year.

![Sample Active Billing Provider Count Graph](image1)

Figure 4 – Sample Active Billing Provider Count Graph

• Service Penetration Rate - stratified by HSR grouping. The penetration rate is calculated by dividing the number of service utilizers by the total number of members eligible to receive the service. In all instances this is the total Medicaid population receiving fee-for-service benefits. The exception is for pre- and post-natal obstetric care, where the denominator is limited to the female Medicaid population receiving fee-for-service benefits. Trends are examined in monthly increments, for calendar years 2016, 2017 and 2018.

![Sample Penetration Rate Graph](image2)

Figure 5 – Sample Penetration Rate Graph

• Snapshot of Demographic Groups by Utilizer Count - for calendar year 2018. This metric depicts the group distribution (children, adults, individuals with disabilities – children, individuals with disabilities – adults) of service utilizers.
  - Demographic Technical Definitions:
    - **Child**: means any child member, aged 17 and under, with an eligibility type of:
      - MAGI Eligible Children
• Foster Care
• SB11-008 Eligible Children
• BC Children (child dependents of a woman enrolled in the Breast and Cervical Cancer Program).

- **Adult**: means any adult member, ages 18 and older, with an eligibility type of:
  - OPA-A (old age pension)
  - MAGI Adults
  - BC Women
  - Non-Citizen (emergency services)
  - Partial Dual Eligible
  - SB11-250 Eligible Pregnant Adults

- **Individual with a Disability**: means any adult or child member, of any age, with an eligibility type of:
  - OAP-B-SSI
  - AND/AB-SSI
  - Buy-in: Working Adults with Disabilities
  - Buy-in: Children with Disabilities

![Figure 6 – Sample Demographic Chart](image)

- Snapshot of Age and Gender Groups by Utilizer Count – for calendar year 2018. This metric depicts the gender and age distribution of service utilizers.

![Figure 7 – Sample Age and Gender Chart](image)
Colorado Health Access Survey

The Colorado Health Access Survey (CHAS) is a biennial survey of 10,000 Colorado households, administered during the spring of each reporting year by Social Science Research Solutions (SSRS), an independent research company contracted by the CHI. Survey questions focus on health insurance coverage, access to health care, and use of health care services in Colorado. The survey allows for comparisons across demographics, payer types (e.g. Medicaid, other public insurance, and commercial insurance), regions, and across a time marked by sweeping changes in health policy.

The Department funded additional questions for inclusion in the 2017 CHAS to better understand member access to services and how that access compares to other Coloradans in the same geographical region.

CHAS Methodology

2013, 2015, and 2017 survey data was weighted by CHI to accurately reflect the demographics and distribution of the State’s population. Missing values for income variables were calculated using a regression approach. To ensure statistical soundness, results with small pre-weighted sample sizes and/or large confidence intervals were excluded from the access to care data.

In some instances, the CHAS sample size was not large enough to report a value. Due to missing values, report totals do not always match demographic totals. Additionally, these values are based on survey data and may not match official Colorado Medicaid caseload figures.

The term ‘significant’ is used throughout this report when discussing CHAS data. It refers to differences, between populations and between years, that are statistically significant at the 95% confidence level, meaning differences between two groups are only 5% (or less) likely to have occurred by chance. A 5% significance level is not the same as a 5% difference between two values. While CHAS graphs in this report may depict differences greater than 5%, such differences may not be statistically significant because factors such as sample size and the number of respondents to a particular question did not allow CHI to establish significance at the 95% confidence level. Differences of less than 5% may still be statistically significant if the sample size is large enough.

For more information about the CHAS and to view CHAS results, see: http://coloradohealthinstitute.org/
Data Points

For the Primary Care analysis, the following CHAS data points are analyzed:

- Usual source of care;
- Usual source of care is a doctor’s office;
- Usual source of care is a community health center;
- Reasons for not having a usual source of care;
- Visited a health care professional;
- Had a preventive care visit;
- Last ER visit was for a non-emergency;
- Skipped general doctor care due to cost;
- Told doctor wasn’t accepting insurance; and
- Skipped care because doctor’s office was too far away.

For Physician Specialist Services, the following CHAS data points are analyzed:

- Visited a specialist in the last 12 months; and
- Skipped specialist care due to cost.

While there is no absolute metric to assess access to care, the above survey points, evaluated together, are suitable proxy measures.

Stakeholder Feedback

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for services. The Department has also put in place several mechanisms for soliciting ongoing provider and member feedback. Staff address and catalogue this feedback in accordance with the procedures detailed in Appendix D – Access Issues. Stakeholder feedback appears in this report in the following areas:

- Rate Comparisons, where a service was reviewed through the Department’s Rate Review process and stakeholder feedback was received
- Input from Beneficiaries, Providers, and Stakeholders sections in each of the five service categories.

9 Funded by the Department to further evaluate access
Access Analysis Data Limitations

To be counted as a Medicaid member receiving fee-for-service benefits for this report, members must have been enrolled for at least six months. The alternative is to capture members enrolled on the last day of the calendar year. The six-month threshold was chosen as the appropriate measure as it ensures that a majority of members are captured for the reporting period rather than just those enrolled on the last day. It also allows for a more accurate picture of ongoing member care.

Rendering and billing provider counts are captured on the last day of the calendar year. This avoids a known data discrepancy stemming from a Department data system change in 2017.\textsuperscript{10} Capturing the last day of the calendar year also avoids duplicate counting during the system change period and minimizes the issue of convergent systems data.

Procedures to Monitor Access

Monitoring Procedures
As part of the Department’s ongoing activities to ensure sufficient access to care for our members, service utilization will be monitored annually in accordance with the utilization metrics and methodologies described in this plan.

When data analysis identifies an access issue, the Department will initiate a process to examine the utilization data in greater detail. After further data examination, the Department will coordinate with local entities (such as the RAEs) to investigate the issue. If the issue is substantiated, it will be designated as an access deficiency, which triggers the requirements of 42 CFR 447.203(8). See Appendix D – Access Issue Workflow

Remediation of Inadequate Access to Care
If an access deficiency is identified the Department will Notify CMS within 90 days. This notification will include a Corrective Action Plan, which details specific steps and timelines to remediate the access deficiency within 12 months.

\textsuperscript{10} There are some discrepancies between the new and old systems as members were gradually reenrolled into the new system over a period of time.
Comparative Reimbursement Rate Review Data Sources

Medicaid reimbursement rates are compared to Medicare reimbursement rates and Medicaid reimbursement rates in other states (Arizona, California and Wyoming), by procedure code (CPT). For full rate comparison see Appendix E - Rate Review Comparison Workbook.

A comparison with commercial insurance reimbursement rates was not undertaken for this report. Existing commercial rate information is incomplete and not appropriate for use in comparison. For example, the Department may reimburse a specific service using revenue codes, whereas commercial insurers may use the Healthcare Common Procedure Coding System (HCPCS) codes – making it impossible to accurately crosswalk the equivalency between the two coding systems and conduct a rate comparison.

The Department continues to work with the Center for Improving Value in Health Care (CIVHC) to improve the Colorado All Payer Claims Database (APCD). The APCD includes claims data from commercial insurers, however, it does not presently provide a full picture and is not recorded in the same way as Medicaid and Medicare rates, making direct comparison extremely difficult.

Rate Review Methodologies and Assumptions

The rates comparison was conducted using the Medicaid Access Payment Rate Comparison Tool (V. Sept, 2018) developed by Mathematica and provided to each Medicaid State by the Centers for Medicare & Medicaid Services (CMS) for the purposes of reporting on the AMRP.

The tool calculates both unweighted and weighted percentage comparisons. The unweighted comparisons calculate the simple average of Colorado’s Medicaid reimbursement rates within a service category, in effect assuming the same volume of services for each CPT/Provider Type/Rate Type combination in the service category. This simple average is compared to the simple average for the same CPT/Provider Type/Rate Type combination in the comparison payment rate data.

Per Mathematica “the weighted percentages assume that the volume of services associated with each CPT/Provider Type/Rate Type combination in the comparison payment rate data equals the volume of services associated with each these combinations in the state’s own Medicaid data. That is, the weighted percentages consider Colorado’s own Medicaid service “market basket” when comparing payment rates in each service category”.

11 Fulfills requirement 42 CFR 447.203(b)(3)
Rate comparison tables found in this report show aggregate weighted percentage by CPT code and service type for the following service categories; primary care, physician specialist services, fee-for-service behavioral health services, and pre- and post-natal obstetric services (including labor and delivery).

Home health rates were manually compared to other comparator states. The Mathematica tool was not used as it only captures CPT procedure codes and home health services are billed using revenue codes.

The Department has also included rate comparison information from its existing Rate Review process (outlined below) for certain service categories. Where results converge or diverge the Department has explained the reasons for this including different methodologies, time periods and code sets.

**Rate Review Data Limitations**

Claims data used for this analysis only reflects claims paid in FY 2017-2018. Medicare rates data used for this analysis did not vary by place of service. Rates from Arizona, Wyoming, and California’s Medicaid programs used in this analysis do not have modifiers\(^\text{12}\); rates are only compared with Colorado Medicaid rates and Medicare rates that do not have modifiers.

Rate comparisons alone are not appropriate to determine 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 higher than their optimal level may lead to increases in unwarranted utilization or utilization of low-value services and rates that are less than 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.

12 A CPT modifier (also referred to as Level I modifier) is used to supplement information or adjust care descriptions to provide extra details concerning a procedure or service provided by a physician. Code modifiers help further describe a procedure code without changing its definition

13 As the states being compared with do not use modifiers, the Department was unable to compare the same number of codes with each state as was compared with Medicare. Approximately 30% of codes that were compared with Medicare (those with modifiers) were not compared with other states. The Department compared 1573 codes with Medicare rates (1088 were unique codes without modifiers) – with other states the Department compared 1097 (69.7% of Medicare codes).
Special Provisions for Proposed Provider Rate Reductions or Restructuring\textsuperscript{14}

In accordance with the Plan, The Department submits an Access Monitoring Analysis Review with any State Plan Amendment (SPA) proposing to reduce provider payment rates or restructure provider payments. Monitoring procedures (as described in the Monitoring Procedures subsection of this Plan) will be put in place for a period of at least three years after the effective date of any SPA that authorizes the payment reductions or restructuring.

Access Monitoring Analysis Reviews – 2016-2018
Since the 2016 Plan the Department has had one SPA that proposed a rate reduction which invoked the need for an access analysis (SPA 16-007). The analysis showed that the change in reimbursement for Evaluation & Management and Vaccine Administration services was not expected to have an effect on access for Colorado Medicaid clients (Appendix F– Evaluation & Management and Vaccine Administration Services Access Analysis). The Department is continuing to monitor utilization of these codes to ensure that there is no ongoing impact on access.

\textsuperscript{14} Fulfills requirement 42 CFR 447.203(b)(6)
General Demographics

The population of Colorado was 5.69 million as of 2018 and is rapidly growing, with an increase of 13.2% since 2010\(^\text{15}\). Health First Colorado (Colorado’s Medicaid Program) provides coverage to more than 23.4% of the State’s population\(^\text{16}\). A general demographic breakdown of the Colorado Medicaid population in 2018 is found below (for a full breakdown see Appendix A – Fee for Service Member Demographics).

<table>
<thead>
<tr>
<th>Statistic</th>
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<td><strong>Gender</strong></td>
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<tr>
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<tr>
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<td>52.97%</td>
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<td><strong>Age</strong></td>
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<tr>
<td>0 to 5</td>
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<td>12 to 17</td>
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<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td>Hispanic</td>
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<tr>
<td>Other/Not recorded/Not disclosed</td>
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<tr>
<td><strong>Income Relative to Federal Poverty Level (FPL)</strong></td>
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<tr>
<td>0-68% of the FPL</td>
<td>56.60%</td>
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<tr>
<td>69%-133% of the FPL</td>
<td>29.05%</td>
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<tr>
<td>134%-142% of the FPL</td>
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<tr>
<td>143%-195% of the FPL</td>
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</tr>
<tr>
<td>196%-300% of the FPL</td>
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<tr>
<td>301%-450% of the FPL</td>
<td>1.26%</td>
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\(^{15}\) Source: Us Census Bureau  
\(^{16}\) Source: HCPF State Fact Sheet
Table 1: 2018 Colorado Medicaid FFS Member Demographic Data

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<td>Spanish</td>
<td>8.49%</td>
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<tr>
<td>Other</td>
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<tr>
<td>Burmese</td>
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<td>Arabic</td>
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<td>Somali</td>
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<td>Russian</td>
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<tr>
<td>Nepali</td>
<td>0.04%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.03%</td>
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</table>

The Colorado Health Institute (CHI) compared Medicaid demographics with other payer types and the state as a whole. This analysis is included in Appendix B – Colorado Health Institute Demographic Data. The results are extrapolated from findings in their 2017 Colorado Health Access Survey (CHAS), a 10,000 household self-reported survey. As such Medicaid results differ from actual enrollment data presented above in certain key demographics, such as gender and income level. Nevertheless, the CHI analysis is included in the appendices for the purpose of making general demographic comparisons across payer types.

17 Spoken language total will not equal 100% - there are numerous smaller languages which are not presented here due to sample size restrictions.
The Sufficiency of Access to Care for Medicaid Members in Colorado

For full data workbook see – Appendix G – Member Needs Data Workbook

Primary Care Services
For full data workbook see – Appendix H – Primary Care Services Data Workbook

Definition of Service
Primary care is generally the first level of contact the public has with the medical care system. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, etc.)

Children visit a primary care provider more often than adults, to evaluate growth. Adults use primary care services for specific issues and for preventive services. All Colorado Medicaid members are eligible to receive primary care services.
Characteristics of the Member Population

Figures 9 and 10 contain demographic information about those Colorado Medicaid members who utilized primary care services in calendar year (CY) 2018, including the number, age and gender of service utilizers.

The age and disability distribution pattern in Figure 9 is similar to the general distribution of all Colorado Medicaid program members in CY 2018. Over the past three years, the percentage of adults and individuals with disabilities utilizing services increased relative to the percentage of children utilizing services. This is consistent with expectations and likely due to the increase in adult enrollment as a result of the Affordable Care Act (ACA) expansion. The ACA expansion also led to an increase in the number of members aged 21-39 receiving primary care services. A larger percentage of women utilized primary care in CY 2018 compared to the national average. Colorado Medicaid provides coverage to half of all pregnant women in the state, and while covered, pregnant women are eligible for the full spectrum of Medicaid benefits, including primary care services.

Fulfills requirement 42 CFR 447.203(b)(iv)
The number of Colorado Medicaid members utilizing primary care services increased, from an average of 149,000 members per month in 2016 to an average of 189,000 in 2018. The trend shows varied usage during the course of the year with seasonal decreases in July and December of each calendar year. The Department will continue to monitor the number of members utilizing primary care services to ensure that the decrease in December 2018 was part of the ongoing seasonal trend rather than the beginning of an overall decrease in member utilization.

In the most recent month of data, December 2018, the percentage of members accessing primary care in each region ranged from 15.03% in the San Luis Valley to 17.73% in Northern Colorado. Various geographic and socio-economic factors impact member utilization, particularly in December 2018, when weather, seasonal travel, and temporary facility closures for the holidays may have had an impact\(^\text{19}\).

\(^{19}\) The variations between regions throughout the year is expected. Geographic and socio-economic factors impact the different levels of utilization between regions of the state. The areas of the state which are the most remote and have the most dispersed members see slightly lower levels of utilization than those in metro and urban areas where member populations are more densely located, and distance required to travel to a provider is less. Areas of the state where geographic barriers exist (such as mountain ranges) or more extreme weather occurs (e.g. higher snow levels during winter) tend to access services at a slightly lower rate than areas where these potential barriers do not exist.
The number of providers delivering primary care services to Colorado Medicaid members increased from 9,088 in January 2016 to 10,311 in December 2018.

The decrease observed in March of 2017 is artificial. It coincides with the roll-out of a new Medicaid Management Information System (interChange) and the requirement that providers re-enroll as Colorado Medicaid providers within the new system.

Since the data system change, the number of providers has remained relatively steady with slight increases in most regions. As with utilizer data, it appears that there was a seasonal decrease in the number of providers delivering services in December of each year.
The penetration rate (e.g. the extent to which those eligible to receive the service utilized the services) was fairly consistent across all seven regions. The overall percentage of members accessing services has trended upward over time.

In the 2016 AMRP, the Department identified that HSR 8 (HSR grouping 4, San Luis Valley) required monitoring due to a decrease in the penetration rate over the previous time period observed. The data in this report shows that the penetration rate in HSR 8 has increased from 9.83% in January 2016 to 11.28% in December 2018. The penetration rate in HSR 8 was at 20.92% in October 2018 before a likely seasonal decrease in November/December 2018.

The penetration rate in HSR 8 in the 2016 AMRP fell from approximately 25.00% in January 2014 to 16.00% in July 2015. While the penetration rate has not returned to the January 2014 high, for the last two years (2017-2018) the penetration rate has, outside of seasonal dips, returned to higher than the 16.00% recorded in June 2015, with a monthly average higher than 18.00% during the reporting period.

The Department also looked at primary care access for HSR 8 through the 2018 Rate Review process. The 2018 Rate Review Analysis report looked at access to primary care services.
reviewed in this Plan and each HSR was given an Access to Care Index (ACI)\textsuperscript{20} score relative to the other HSRs. HSR 8 was among the higher scores for the state, when compared to other HSRs\textsuperscript{21}.

Colorado Health Access Survey Data

As the Colorado Health Institute (CHI) reported in the 2017 Colorado Health Access Survey (CHAS) report\textsuperscript{22}, nine of 10 Colorado Medicaid members were happy with the range of services covered, trailing only Medicare, and eight of 10 were happy with their choice of doctors, a better rate than those with individual coverage. CHI also found that 81.0\% of Medicaid clients said their family’s needs were being met by the health care system, higher than any insurance type, including employer-sponsored insurance.

Key survey findings as pertains to evaluating access to primary care services are listed below and included: the number of members who had a usual source of care; why and whether members received routine care; usage of the emergency room for non-emergent services, and reasons why members skipped needed care.

\textit{Visited a Health Care Professional}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Fig14.png}
\caption{Percentage of Respondents who Visited a Health Care Professional, by Insurance Type}
\end{figure}

\textsuperscript{20} The Access to Care Index (ACI) is a tool to standardize the access to care metrics across each service category for the Department’s Rate Review process. It measures performance against five metrics: penetration rate; time and distance standard; member to provider ratio; active provider months and panel estimate.

\textsuperscript{21} For more information on ACI methodology see page 2 of Appendix C of the 2017 Rate Review Analysis report - https://www.colorado.gov/pacific/sites/default/files/Physician%20Services%20Appendix%20C%20Access%20Analysis%20Methodology.pdf

\textsuperscript{22} Source: 2017 Colorado Health Access Survey. For more information see: https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2017
The percentage of Colorado Medicaid respondents who visited a health care professional remained steady (77.9%) from 2013 to 2017. There was a small increase (82.0%) in 2015 in line with the Affordable Care Act (ACA) expansion, but this returned to previous levels as the number of expansion members declined. This reduction was also observed at the national level; Medicaid enrollment fell on average by 1.55% in 2018 for those states that expanded Medicaid\textsuperscript{23}. This may be attributed to several factors including a decrease in the national unemployment rate and more Coloradans gaining employment over the period.

Members were equally likely to visit a healthcare professional across the seven regions of the state, with the lowest percentage (73.3%) of members visiting a health care professional in the Eastern Plains region and the highest (82.4%) in the Metro Denver (West and South) region.

In 2013, 2015 and 2017, Medicaid members were not significantly more or less likely to have visited a health care professional than other commercially insured or public insured Coloradans and were significantly more likely to visit a health care professional than uninsured Coloradans.

Had a Preventive Care Visit

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure15}
\caption{Percentage of Respondents who had a Preventive Care Visit, by Insurance Type, State Average, 2017}
\end{figure}

\textsuperscript{23} Source: A2 Group. For further information see: https://www.medicaidplans.org/_docs/Enduring_State_of_Medicaid.pdf
In 2017 Colorado Medicaid respondents were less likely than the commercially insured and those with other public insurance to have had a preventive care visit, however these results are not statistically significant\(^{24}\).

Colorado Medicaid members in the Eastern Plains (55.1%) and San Luis Valley (52.7%) regions of Colorado were less likely to have had a preventive care visit than the state Medicaid average (58.2%). In the Eastern Plains this was not statistically significant and was in line with other payer types in the region. The lower rate in the San Luis Valley was statistically significant when compared to other payer types. Members in the Metro Denver (West and South) and Colorado Springs/Pueblo regions were more likely (62.7 % and 61.8%, respectively) to have had a preventive care visit.

There are numerous factors which may impact a Medicaid member’s willingness or ability to access preventive care, many of which are socio-economic and not indicative of a broader access to care issue. A 2015 study, *Why do People Avoid Medical Care?*, cited the following factors:

- Unfavorable evaluations of seeking medical care, such as factors related to physicians and health care organizations;
- Low perceived need to seek medical care; and
- Traditional barriers to medical care such as high cost, no health insurance, and time constraints\(^{25}\).

The first two are mindsets that are not easily changed regardless of actions taken to remove traditional access barriers.

The Colorado Health Institute noted in their recently released *2019 Medicaid and Commercial Insurance Access to Care Index* that “broader socioeconomic disparities ... exist between the commercially insured and Medicaid members, including employment and unemployment status, educational attainment, and the levels of intergenerational wealth or poverty”. These factors may impact Medicaid members willingness and ability to access preventive care. CHI also noted that “Medicaid serves a disproportionate number of pregnant women, older adults, and people with complex medical conditions and disabilities when compared with the state’s population.” This differing level of health complexities faced by Medicaid members compared to the general population may contribute to a lower rate of preventive care if members are already receiving care and management for longer term health issues.

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\(^{24}\) The term ‘significant’ refers to differences, between populations and between years, that are statistically significant at the 95% confidence level, meaning differences between two groups are only 5% (or less) likely to have occurred by chance. While data may depict differences greater than 5%, such differences may not be statistically significant because factors such as sample size and the number of respondents to a particular question did not allow CHI to establish significance at the 95% confidence level.

Between 2013 and 2017, fewer respondents reported having a usual source of care across payer types: the percentage of individuals with commercial insurance who reported a usual source of care decreased from 87.2% to 86.7%; those with other public insurance decreased from 93.1% to 91.0%; and the uninsured decreased from 54.3% to 50.0%. The percentage of Colorado Medicaid respondents who reported having a usual source of care decreased from 86.0% in 2013 to 82.9% in 2017.26

26 For the purposes of the CHAS, a usual source of care is defined as a place where the respondent usually goes when they are sick or when they need advice about their health.
Across all payer types, the majority of individuals without a usual source of care reported that the reason they did not was that they had no medical problems or did not plan to see a doctor even when sick. These are cultural factors that are unlikely to be addressed by improving other access barriers. Approximately one-quarter (27.0%) of Colorado Medicaid respondents and 30.0% of uninsured respondents reported an ‘other’ reason for not having a usual source of care. Other reasons included the following responses:

- No doctors take my insurance;
- No doctors speak my language;
- Doctor’s office is too far away;
- Doctor’s office is not convenient; and
- Other

Access barriers around insurance acceptance and transportation (too far away or not convenient) are explored later in this Plan.
Respondents were also surveyed on the location of their usual source of care. The most common responses were a doctor’s office or community health center. Between 2013 and 2017 Colorado Medicaid respondents trended away from a community health center (from 37.9% in 2013 to 16.7% in 2017) to a doctor’s office (from 45.6% in 2013 to 59.3% in 2017). Departmental data indicates that members are continuing to receive services at community health centers (such as Federally Qualified Health Centers and Rural Health Centers). The change in percentages may have been affected by members surveyed not understanding the difference between a doctor’s office and a community health center, especially for those members who were newly eligible for Medicaid under the ACA expansion. Community Health Centers play an important role in areas of the State where traditional single practice facilities may not be available.
Emergency Room Visits

The number of Colorado Medicaid respondents reporting use of an emergency room for non-emergent reasons decreased from 55.0% in 2013 to 42.9% in 2017. This trend was seen in nearly all regions of the state; the number of respondent reporting use of the ER increased slightly in two regions (Northwest Colorado and Northern Colorado) during this time period, however this increase was not significant.

In Metro Denver (West and South), among members who reported access to alternative sources of care, such as urgent care facilities, there was a statistically significant decrease in usage of the emergency room for non-emergent reasons (from 59.9% in 2013 to just 18.4% in 2017).

Potential Access Barriers

The CHAS survey asks members the reasons why they skipped needed general doctor care. Four key barriers are considered: cost; doctor not accepting new patients; doctor not accepting insurance type; and transportation.
The number of Colorado Medicaid respondents who reported skipping general doctor care due to cost in the past 12 months increased from 2013 to 2015 and fell slightly in 2017. Certain regions of the state saw significant increases (from 3.1% in 2013 to 18.0% in 2017 in the San Luis Valley), while others saw significant decreases (12.4% to 6.7% in Metro Denver).

It is important to note that Medicaid members typically pay a $4 copay for an outpatient visit and a $3 co-pay for prescription drugs (NB: these amounts were $3 and $1 at the time of the 2017 CHAS); the copay can go up to $6 in the case of non-emergent visits to the emergency room and to $10 for an inpatient stay. There is also a monthly co-pay maximum of 5% of a Medicaid member’s household income. This means, once any Medicaid eligible member(s) of the household has paid copays totaling 5% of household income, no one in the household has to pay additional co-pays for the rest of that month. There is also no deductible or out-of-pocket maximum. So, when Colorado Medicaid members report cost is a barrier to care, it is likely that they are considering the full cost of care, including secondary costs such as car parking, transportation, babysitting, and time off work, rather than the nominal healthcare costs payable as a Medicaid enrollee.²⁷

²⁷ The Colorado Health Institute notes “Medicaid members reported greater cost concerns than commercially insured people despite not paying health insurance premiums and having limited co-pays. This is an area ripe for future research...Another reason may be the comprehensive costs of seeking care as a low-wage earner. Seeing a doctor sometimes means a day without pay, plus other costs such as gas or bus tickets and co-pays. Moreover, Medicaid members in Colorado report lower levels of being treated respectfully by providers than those with commercial insurance. That total experience can be costly both financially and in terms of time and stress.”
The number of Colorado Medicaid respondents who reported not getting needed care because the doctor’s office was not accepting their insurance type increased between 2013 and 2017. While data elsewhere in this report shows that the number of providers remained relatively consistent and that the number of services being delivered has increased, members still report not being able to get care from their preferred provider.

The Department conducts an annual client satisfaction survey, CAHPS (Consumer Assessment of Healthcare Providers and Systems), that asks about the reasons members did not access care they or their doctor believed they needed in the previous 12 months. In 2018, roughly one in ten Colorado Medicaid adult members surveyed, and less than one in twenty child members surveyed, indicated they were unable to access care at some point in the previous year. Of those who reported they were unable to access care, only one in twenty adults and one in ten children reported a provider’s refusal to accept Medicaid as the reason. While these numbers, as a percentage, are smaller than the numbers reported on the CHAS, the respondent sample size was too small to extrapolate a representative sample of all Colorado Medicaid members.28

The distribution in Figure 21 above is not unique to Colorado. A recent 2019 Medicaid and CHIP Payment and Access Commission report noted that, nationally, providers are less likely

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28 Source: 2018 CAHPS Survey. For more information, see: https://www.colorado.gov/pacific/hcpf/client-satisfaction-surveys-cahps. In the 2018 CAHPS survey, which received responses from 1,901 adult members and 2,063 child members (through a parent or guardian), members were asked about the main reason they were not able to get medical care, tests, or treatments that they or a (any) doctor believed necessary. 173 adult members (9.1% of total survey respondents) answered the question. Of those, nine (5.2% of respondents who answered the question) reported that their provider refused to accept Medicaid. Just 49 child members (2.3% of total survey respondents) answered the question and of those, seven (14.3% of respondents who answered the question) reported that their provider refused to accept Medicaid.
to accept new patients insured by Medicaid (70.8 percent) than those with Medicare (85.3 percent) or commercial insurance (90.0 percent).²⁹

The percentage of Colorado Medicaid respondents who were told by a doctor’s office that they were not accepting new patients increased slightly in 2017, but this increase was not statistically significant.³⁰ Increased numbers of respondents with commercial insurance (from 6.1% in 2013 to 8.5%) and of those with other public insurance (from 5.7% to 10.6%) also reported being told by a doctor’s office that they were not accepting new patients. These increases were statistically significant.

In April 2018, the Department undertook a secret shopper telephone survey of a random sample of primary care providers’ offices to determine if, and to what extent, practices were accepting new patients and Medicaid as payment and, if so, were members able to get a timely appointment and appropriate information. In total, 205 offices were called and provided responses. Of those, 187 offices indicated that they were accepting Medicaid as a payment type and, of those, 148 indicated that they were accepting new patients (79.1%). Of those, 117 appointments (79.1%) were scheduled and the average wait time recorded in the survey was 16.9 days.

When an office responded they accepted Medicaid and were accepting new patients, the office was called back at a later date to see how responses changed when the payment type

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²⁹ Source: MACPAC. For more information, see: [https://macpac.gov](https://macpac.gov)  
³⁰ Two regions reported lower rates of being told by a doctor’s office that they were not accepting new patients, Eastern Plains and Colorado Springs/Pueblo. One region recorded a larger increase between 2013 (11.7%) and 2017 (26.6%) – Metro Denver (West and South) – however this was not statistically significant due to the sample size surveyed.
was changed to commercial insurance. One hundred and eighteen (of 120) offices indicated that they were accepting commercial insurance as payment. Ninety-seven percent reported they were accepting new patients. Of those, 102 were able to schedule an appointment (88.7%), which is a greater percentage than Medicaid (79.1%). However, the average wait time (from request to date of appointment) was 17.2 days for the commercially insured, while the average wait time for Colorado Medicaid members was only 16.9 days. When Colorado Medicaid members successfully scheduled an appointment, they were able to be get an appointment sooner than the commercially insured.

![Figure 23](image.png)

*Figure 23 – Percentage of Respondents who Reported not Getting Needed Care Because the Doctor's Office was Too Far Away, State Average by Insurance Type & Year*

The geographic realities of the state make transportation a potential barrier to accessing needed services for some Colorado Medicaid members. Between 2015 and 2017, there was a small increase in the number of Colorado Medicaid members who reported they did not get care due to the doctor’s office being too far away. However, this number remains smaller than the number reported in 2013.

As expected, respondents in more remote regions reported more instances of missing care due to transportation. However, Colorado Medicaid members surveyed in the two metro regions also reported more instances. As mentioned previously in this Plan, the Department has since implemented initiatives to improve access to transportation in metro Denver locations and it is anticipated that this will be reflected in the upcoming 2019 and 2021 CHAS survey responses.

The Department also worked with stakeholders during the 2017-18 legislative session to co-author legislation that will create an urgent transportation benefit for those needing urgent but not emergent medical transportation, effective summer of 2020. This benefit is expected
to address fragmentation of transportation services by bridging the gap between emergent and non-emergent transportation, which usually requires 48-hour notice.

For more information on the Department’s efforts to address transportation barriers see page 15 - *Ensuring and Improving Access to Care in Colorado*.

**Primary Care Services Health Professional Shortage Areas**

Primary care, dental, and mental health Health Professional Shortage Areas (HPSAs) are designated, scored and monitored by the Health Resources and Services Administration (HRSA). HPSAs may be geographic-, population-, or facility-based. Geographic shortages relate to the entire population within a defined area and population shortages relate to a shortage of providers for a specific population in a geographic area (such as low-income, migrant farmworkers, and other groups). Colorado does not have any specific Medicaid Eligible Population HPSAs.

![Figure 24 – Primary Care Health Professional Shortage Areas (HPSAs)](image)

In Colorado there are currently 32 primary care geographic HPSAs (in 25 of Colorado’s 64 counties). It is important to note that geographic HPSAs relate to the entire population of that region, not just the Medicaid population. Of these 32 primary care geographic HPSAs, two HPSAs have a rating at the low end of the scale (indicating a slight shortage), 21 have a

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31 Source: HSRA. For more information on HSPAs, see: [https://bhw.hrsa.gov/](https://bhw.hrsa.gov/)

32 State Primary Care Offices submit applications to designate all HPSAs – in Colorado this is the Colorado Department of Public Health and Environment. HRSA reviews applications to determine if they meet the eligibility criteria for designation. The main eligibility criterion is that the proposed designation meets a threshold ratio for population to providers. Once designated, HRSA scores HPSAs on a scale of 0-25 for primary care and mental health, and 0-26 for dental health, with higher scores indicating greater need.
rating in the mid-range, and one area, Gilpin County, is classified as having a greater need with a rating of 19/25. Those areas with scores on the higher end of the scale have been identified as having the greatest priority for assigning clinicians and addressing professional shortages through various federal and state government initiatives such as loan waiver programs. Areas with higher scores are also eligible to have clinics in that location deemed Rural Health Clinics by CMS, providing enhanced reimbursement.

While access to primary care in the HPSAs can be improved, data from this plan and the Department’s Rate Review process demonstrate that the problem is not unique to Medicaid, and in reality, Colorado Medicaid members may have better access to primary care services than the general population. For example, the 2018 Rate Review Analysis report, which reviewed access to primary care services, found that access in northwestern corner of the state (Jackson, Moffat, Rio Blanco, and Routt counties), which have been deemed HPSAs, was among the best in the state for Medicaid, scoring 90/100 on access to primary care. Similarly, parts of Custer County have been deemed a HPSA, yet the Department’s analysis found that access to primary care was sufficient, with the region scoring 80/100.

The data analyzed in this Plan has also shown that despite HPSAs having been identified in parts of the state, more members than ever have been able to access primary care services, while both provider levels and penetration rates have also increased.
Primary Care Services Drive Time Mapping

The Department has invested in geospatial mapping technology to measure the distance that a member must travel to their nearest primary care provider. This is calculated as actual drive time and considers roads and traffic information.\(^{33}\)

![Drive Time Mapping Map](image)

*Figure 25 – Primary Care Drive Time Mapping – Potential Access*

More than 99.4% of fee-for-service Colorado Medicaid members live within 30 minutes’ drive time of a primary care service provider. An additional 0.35% live within 30 to 45 minutes’, and 0.13% within an hour. Most areas where the remaining 0.05% of members live (more

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\(^{33}\) This is a measure of potential access. The Department continues to improve its data capability and may include maps of realized access (e.g. where members actually received services in relation to their residence) in future iterations of this report.
than an hour away from their nearest primary care provider) are regions where the terrain is less accessible, primarily due to mountain ranges.

**Primary Care Services Rate Comparison**

<table>
<thead>
<tr>
<th>Reimbursement Type</th>
<th>Aggregate Percentage Primary Care Medicaid Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>78.70%</td>
</tr>
<tr>
<td>Arizona Medicaid</td>
<td>98.24%</td>
</tr>
<tr>
<td>California Medicaid</td>
<td>147.14%</td>
</tr>
<tr>
<td>Wyoming Medicaid</td>
<td>81.92%</td>
</tr>
</tbody>
</table>

*Table 3 – Primary Care Medicaid Rate Comparison to Other Payment Types, Aggregate Percentage*

The Department compared 2018 fee-for-service Colorado Medicaid reimbursement rates with four other payers: Medicare; the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid.

In aggregate, Colorado Medicaid primary care reimbursement rates were equivalent to Arizona rates and significantly higher than rates paid to primary care providers in California. The Colorado aggregate percentage was lower than Wyoming, however, Wyoming serves a much smaller Medicaid population\(^{34}\). In aggregate, Colorado Medicaid primary care reimbursement rates were just below 80% of the equivalent Medicare rates.

The Department also reviewed primary care reimbursement rates in 2018 through the Rate Review process in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. The 2018 Rate Review report found that evaluation & management and primary care rates in Colorado were at 85.09% of the benchmark (which, in most cases, was Medicare; where Medicare was not an appropriate comparator, the benchmark was an average of seven comparable Medicaid states). These results largely align with the findings above. Differences in findings can be attributed to a difference in methodology and measurement tools, and the Rate Review process assessing a smaller subset of primary care procedure codes, as well as potential fee schedule differences that may have been introduced since the 2018 Rate Review analysis was conducted.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare.\(^{35}\)

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\(^{34}\) As of March 2019, Wyoming Medicaid was serving 55,000 members.

\(^{35}\) When Medicare is not an appropriate model, the Department 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 the Department views reimbursements between 80% - 100% of Medicare and reimbursements 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 reimbursements at a certain amount; investigating if a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies; identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and developing systems to ensure that reimbursements are associated with high-quality provision of services.
The 2018 Rate Review report recommended a budget-neutral rebalancing of certain individual evaluation & management and primary care rates with reimbursements less than 80% and higher than 100% of the benchmark. The Colorado legislature approved the budget neutral rebalancing of rates. Outside of the Rate Review process, the Department is adjusting the implementation of the Alternative Payment Model (APM) for participating practices.

Primary Care Services Input from Beneficiaries, Providers, and Stakeholders

The Department reviewed primary care service rates through the Rate Review process in 2017 and 2018. No stakeholder feedback was received by the Department through this process.

Over the past three years, the Department has received feedback on access to specific primary care services in specific regions of the state or for specific populations. When the Department has received such requests, it has undertaken an evaluation. If adequate information to resolve a concern already existed, a change was implemented. If not, an evaluation design is created, and an analysis undertaken. Stakeholders are involved throughout the entire process, including informing the evaluation design and the analysis stage.

Public comment period comments to be inserted here

Additional Analysis Planned as a Result of This Review

The analysis conducted for this Plan has assisted staff to identify potential areas for further investigation. The Department plans to undertake access analysis on the following:

- Increased self-reported usage of the emergency room for non-emergent reasons in Northwestern and Northern Colorado
- Access to primary care services in the San Luis Valley region, including utilization and barriers to care.

The Department will also conduct ongoing monitoring of primary care utilization data through 2019 to ensure that decreases seen in December 2018 are part of the yearly seasonal trend rather than the beginning of a downward trend.

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Physician Specialist Services
For full data workbook see – Appendix I – Physician Specialist Services Data Workbook

Definition of Service
Colorado Medicaid covers specialty services delivered by an enrolled licensed provider, when determined medically necessary, in a clinic, providers’ office, an ambulatory surgery center, outpatient hospital department, or inpatient hospital department. While primary care providers deliver preventative and comprehensive care, specialty services often involve treatment for a specific condition, chronic illness or acute event. The majority of utilizers for specialty care services are referred via their primary care provider.

For the purposes of this Plan, the Department classifies physician specialist services as the following categories of services:

- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Immunology (Allergy)
- Neurology
- Ophthalmology
- Orthopedics
• Otolaryngology (ENT)
• Pulmonology
• Radiation Oncology
• Urology
• Vascular Services

Characteristics of the Member Population

Figures 26 and 27 contain demographic information about those Colorado Medicaid members who utilized physician specialist services in calendar year (CY) 2018, including the number, age and gender of service utilizers.

The age and disability distribution pattern in Figure 26 is similar to the general distribution of all Colorado Medicaid program members in CY 2018. The Affordable Care Act (ACA) expansion led to an increase in the number of members aged 21-39 receiving physician specialist services. A larger percentage of women utilized physician specialist services in CY 2018 compared to the State gender distribution because Colorado Medicaid provides coverage to half of all pregnant women in the State. Once enrolled, pregnant women have access to the full spectrum of Medicaid benefits, including physician specialist services.
Physician Specialist Services Utilization Analysis by Geographic Region

The number of Colorado Medicaid members utilizing physician specialist services remained steady between 2016 and 2018, from an average of 66,000 per month in 2016 to an average of 73,000 per month in 2018. The trend shows varied usage across the course of the year with decreases in July and December of each calendar year. This is largely driven by decreased usage of services by children during the summer break, when they are potentially travelling, staying outside the family home, or simply not having issues detected at school (such as a need for eyeglasses). Utilization among children spikes every August when the new school year begins.

The Department will continue to monitor the number of members utilizing physician specialist services to ensure that the decrease in December 2018 was part of the ongoing seasonal trend rather than the beginning of an overall decrease in member utilization.

In the most recent month of data, December 2018, the percentage of members accessing physician specialist services in each region ranged from 4.75% in the San Luis Valley to 7.37% in Metro Denver (North & East). Various geographic and socio-economic factors impact member utilization, particularly in December 2018 when weather, seasonal travel, and temporary facility closures for the holidays may have had an impact.
The number of providers delivering physician specialist services to Colorado Medicaid members decreased from 7,329 in January 2016 to 5,781 in December 2018.

The decrease observed in March of 2017 is artificial. It coincides with the roll-out of a new Medicaid Management Information System (interChange) and the requirement that providers re-enroll as Colorado Medicaid providers within the new system.

Since the data system change, the number of providers has remained relatively steady with minor variations in most regions. As with utilizer data, it appears that there was a seasonal decrease in the number of providers delivering services in December of each year.
The penetration rate was fairly consistent across all seven regions. The overall percentage of members accessing services has trended upward over time.

The 2016 AMRP identified that HSR 19 (HSR grouping 2, Northwestern Colorado) required monitoring after a decrease (from 10.00% to 6.00%) in the penetration rate. The data in this Plan shows that the penetration rate in HS19 further decreased from 6.73% in January 2016 to 5.98% in December 2018. However:

- A change in methodology and provider enrollment IT systems may be contributing to the differing results; and
- The rate increased to 7.21% in October 2018, before an expected seasonal decrease in November/December.

Given the above factors, it appears that the penetration rate has remained relatively stable over the last three years but has not returned to 2014 levels.

The Department also looked at access to select specialty care services in HSR 19 through the 2017 and 2018 Rate Review processes. The 2017 Rate Review Analysis report looked at access to a number of specialty care services reviewed in this Plan and each HSR region was given an Access to Care Index (ACI) score relative to other HSRs. HSR 19 scored highly for

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37 The Access to Care Index (ACI) is a tool to standardize the access to care metrics across each service category for the Department’s Rate Review process. It measures performance against five metrics: penetration rate; time and distance standard; member to provider ratio; active provider months and panel estimate.
all specialty services reviewed, when compared to other HSRs. The lowest scores in HSR 19 were for gastroenterology and cardiology; however, neither score was low enough to indicate an access issue\textsuperscript{38}.

**Colorado Health Access Survey Data**

![Figure 31 – Percentage of Medicaid Respondents who Visited a Specialist in the Past 12 Months, by Insurance Type](image)

The percentage of Colorado Medicaid respondents who saw a specialist in the previous 12 months decreased slightly from 2015 but was still higher than the level reported in 2013. The increase in 2015 was in line with the ACA expansion, but this returned to previous levels as the number of expansion members declined. Other payer types have all reported small decreases in the number of members surveyed who visited a specialist between 2013 and 2017.

Members reporting a visit to a specialist varied across the seven regions of the state, with the lowest percentage of members (29.0\% and 29.6\%) of members visiting a specialist in the Metro Denver (North & East) and Eastern Plains regions, and the highest (45.1\%) in Northern Colorado. The percentage of members self-reporting a visit to a specialist decreased in the San Luis Valley (from 36.8\% in 2013 to 29.6\% in 2017). While this decrease was not statistically significant, the San Luis Valley has been identified by the Department as a region for ongoing access analysis.

\textsuperscript{38} For more information on ACI methodology see page 2 of Appendix C of the 2017 Rate Review Analysis report - [https://www.colorado.gov/pacific/sites/default/files/Physician%20Services%20Appendix%20C%20Access%20Analysis%20Methodology.pdf](https://www.colorado.gov/pacific/sites/default/files/Physician%20Services%20Appendix%20C%20Access%20Analysis%20Methodology.pdf)
The percentage of Medicaid members surveyed who reported skipping specialist care due to cost remained fairly steady in all regions from 2013 to 2017, and higher among Colorado Medicaid members and the uninsured. As mentioned in the Primary Care section of this plan (pp. 46) Medicaid members have very low co-pays, and no deductible or out-of-pocket maximum. This limits the direct Medicaid costs of seeing a specialist; however, members face external costs that may be included in their analysis of cost worthiness, including taking time off work or having to pay for transportation and child care.
Physician Specialist Services Drive Time Mapping

For physician specialist services, the Department mapped three of the most commonly utilized service types – cardiology, pulmonology and otolaryngology (ENT).

More than 98.07% of Colorado Medicaid members receiving fee-for-service benefits live within 30 minutes’ drive time of a cardiology provider. An additional 1.08% live within 30 to 45 minutes’ drive of a provider, and 0.56% within an hour. Most areas where the remaining

39 This is a measure of potential access. The Department continues to improve its data capability and may include maps of realized access (e.g. where members actually received services in relation to their residence) in future iterations of this report.
0.29% of members live (more than an hour away from their nearest cardiology provider) are regions where the terrain is less accessible, primarily due to mountain ranges.

More than 98.06% of Colorado Medicaid members receiving fee-for-service benefits live within 30 minutes’ drive time of a pulmonology provider. An additional 1.18% live within 30 to 45 minutes’ drive of a provider, and 0.44% within an hour. Most areas where the remaining 0.32% of members live (more than one hour’s drive from a pulmonology provider) are regions where the terrain is less accessible, primarily due to mountain ranges.
More than 96.37% of Colorado Medicaid members receiving fee-for-service benefits live within 30 minutes’ drive time of an ENT provider. An additional 1.95% live within 30 to 45 minutes’ drive of a provider, and 1.00% within an hour. Most areas where the remaining 0.67% of members live (more than one hour’s drive from an ENT provider) are regions where the terrain is less accessible, primarily due to mountain ranges.
Physician Specialist Services Rate Comparison

<table>
<thead>
<tr>
<th>Reimbursement Type</th>
<th>Aggregate Percentage Physician Specialist Medicaid Rate Comparison</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>64.05%</td>
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<tr>
<td>Arizona Medicaid</td>
<td>73.12%</td>
</tr>
<tr>
<td>California Medicaid</td>
<td>107.15%</td>
</tr>
<tr>
<td>Wyoming Medicaid</td>
<td>67.69%</td>
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</table>

Table 4 – Physician Specialist Medicaid Rate Comparison to Other Reimbursement Types, Aggregate Percentage

The Department compared 2018 fee-for-service Colorado Medicaid services reimbursement rates with four other payers’ : Medicare; the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid.

In aggregate, Colorado Medicaid’s physician specialist reimbursement rates were slightly higher than the rates paid to physician specialist providers in California. The aggregate percentage was lower than the rates paid in Arizona and Wyoming, however, Wyoming services a much smaller Medicaid population. In aggregate, Colorado Medicaid physician specialist rates were at 64% of Medicare rates.

The Department also reviewed select physician specialist reimbursement rates in 2017 and 2018 through the Rate Review process in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. The 2017 Rate Review report reviewed eight types of physician services – it included six physician specialist services included this Plans analysis – Gastroenterology, Cardiology, Pulmonology (Respiratory40), Vascular, Ophthalmology and Otolaryngology (ENT). The 2017 review also included two physician services not considered a specialty for this report – Speech Therapy and Cognitive Capabilities Assessments. The 2017 report found that the eight-physician service code sets reviewed ranged between 61.61% to 116.83% of the benchmark (which, in most cases, was Medicare; where Medicare was not an appropriate comparator, the benchmark was an average of seven comparable Medicaid states). The majority of rates that were higher than 100% were for Cognitive Capabilities Assessments, which were not included in this Plan’s comparison.

The 2018 Rate Review Report reviewed an additional seven physician service categories – one of which was included as a physician specialist service for this report – Neurology. In

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40 Pulmonology and Respiratory both refer to procedures of the nose, trachea, bronchi, lungs, and pleura (a set of membranes that covers the lungs). This Plan uses the term pulmonology and the Rate Review process uses the term respiratory.
aggregate, the report found that this group averaged 66.96% of the benchmark which is comparable to results of this rate review.

Differences in findings can be attributed to a difference in methodology (including the three additional service types measured in 2017) and measurement tools, the Rate Review process assessing a different set of physician specialist procedure codes, as well as potential fee schedule differences that may have been introduced since the 2017 and 2018 Rate Review analyses were conducted.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare.41

The 2018 Rate Review report recommended that the Department examine individual services that were identified to be less than 80% and higher than 100% of the benchmark to identify services that would benefit from an immediate rate change, as well as services for which a rate change is appropriate due to changes in medical technology. The Colorado state legislature approved the recommendation. The Department is actively working to rebalance rates that are higher than 100% and less than 80% of the benchmark.

Physician Specialist Services Input from Beneficiaries, Providers, and Stakeholders

In the 2016 AMRP, the Department did not identify a physician specialist access issue; however, the Department noted stakeholder feedback suggesting a potential access issue in HSR 16 (HRSG-5 Northern Colorado Region). The Department analyzed data for HSR 16 as part of this report. The number of providers in HSR 16 increased from 867 in March 2017, when the provider enrollment system changed, to 911 in December 2018. The penetration rate in the region remained relatively steady – from 6.29% in January 2016 to 6.18% in December 2018, with a monthly average of 6.18%. This is slightly below the approximate 7.00% recorded at the end of the last AMRP; however, both the methodology and Department IT system have changed during this time period which may have influenced this result.

41 When Medicare is not an appropriate model, the Department 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 the Department views 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 payments at a certain amount; investigating if a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies; identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and developing systems to ensure that payments are associated with high-quality provision of services.
The Department also looked at access to select specialty care services in HSR 16 through the 2017 Rate Review process. The 2017 Rate Review Analysis report looked at access to a number of specialty care services reviewed in this Plan and each HSR region was given an Access to Care Index (ACI) score relative to the other HSRs. HSR 16 scored in the mid-range for all specialty services reviewed, compared to other HSRs. The lowest scores for HSR 16 were for cardiology, respiratory and ENT services – but these scores were not low enough to indicate an access issue. HSR 16 also consistently scored higher than the neighboring HSR 2 – Larimer County.

The data does not indicate an access issue for the broader physician specialist service category; however, the Department will continue to work with stakeholders to investigate specific specialty types to determine if individual specialty providers have decreased in the region.

During the reporting period, stakeholders have raised concerns with the Department regarding unmet physician specialist referrals. The Department is investigating options for measuring and tracking unmet referrals and will continue to explore methods for analyzing this potential issue.

Public comment period comments to be inserted here

Additional Physician Specialist Access Analysis Planned as a Result of This Review

The analysis conducted for this report has assisted staff to identify potential areas for further investigation. The Department plans to undertake access analysis on the following:

- Access to physician specialist services in the San Luis Valley region, including utilization and barriers to care.

The Department will also conduct ongoing monitoring of physician specialist utilization data through 2019 to ensure that decreases seen in December 2018 are part of the yearly seasonal trend rather than the beginning of a downward trend.

The Department will continue to investigate ways in which it can track and measure unmet referrals for physician specialist services – as stakeholders have reported that this is a potential access issue. Unmet referrals could not be tracked as part of this Plan as the data capability to measure unmet referrals does not currently exist and no existing metric is able to report on referrals. Further work will be done with stakeholders and providers to develop a suitable measurement to both monitor and track specialist referrals.

Behavioral Health Services (FFS)\textsuperscript{43}

For full data workbook see – Appendix J – Behavioral Health Services Data Workbook

Definition of Service
This service encompasses fee-for-service Behavioral Health Services for Colorado Medicaid (Colorado’s Medicaid program) members. Most of the Department’s behavioral health services are provided through the capitated behavioral health benefit administered by the Regional Accountable Entities (RAEs) as part of the Department’s Accountable Care Collaborative (ACC); see pp. 13 for more information. Access to care for behavioral health services provided by the RAE networks are not analyzed in this report as it is outside the scope of the regulatory requirements. The RAEs have a robust regulatory framework for ensuring, and reporting, sufficient access to care.

Fee-for-service behavioral health services fall into the following three categories:
- Services provided to members prior to enrollment into a RAE or limited instances when a member does not have enrollment with a RAE.
- Medically-necessary treatment not covered under the capitated behavioral health benefit administered by the RAE.

\textsuperscript{43} Fulfills requirement 42 CFR 447.203(b)(5)(ii)(C)
Short-term behavioral health services provided within the primary care setting. Implemented on July 1, 2018, Colorado Medicaid members are able to receive up to six short-term behavioral health services provided by a licensed behavioral health clinician working as part of a member’s PCMP. These six services are provided on a fee-for-service basis and are not covered by the RAEs.

While the Department has included the same metrics below as included elsewhere in this Plan, it is important to note that, for the reasons stated above, the demographic mix of individuals accessing fee for service behavioral health services is highly variable from year to year and utilization, provider, and penetration rate numbers represent only a fraction of all behavioral health utilization by and provision to Colorado Medicaid members. The data in this report is not a true reflection of the overall Colorado Medicaid member behavioral health experience.

Characteristics of the Member Population

Figures 36, and 37 contain demographic information about those Colorado Medicaid members who utilized fee-for-service behavioral health services in calendar year (CY) 2018, including the number, age and gender of service utilizers.

![Figure 36 – Behavioral Health Utilizers by demographic groups](image)

![Figure 37 – Behavioral Health Utilizers by gender and age](image)

Fee-for-service behavioral health services are primarily utilized by children (71%). Adults generally receive behavioral health services through their RAE network, unless covered by the fee-for-service exceptions outlined above.

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44 Fulfills requirement 42 CFR 447.203(b)(iv)
Behavioral Health Services Utilization Analysis by Geographic Region

Figure 38 – Fee-For-Service Behavioral Health Services Utilizer Count, by HSR Grouping

The number of Colorado Medicaid members utilizing fee-for-service behavioral health services increased between 2016 and June 2018, from an average of 11,600 per month in 2016 to an average of 16,000 per month in 2018. Utilization increased in July 2018 when the Department contracted with Regional Accountable Entities (RAEs) to serve as the single entity responsible for coordinating both physical and behavioral health for Colorado Medicaid (Colorado's Medicaid Program) members and administering the capitated behavioral health benefit. As part of the transition to RAEs, a policy change was introduced that allowed Colorado Medicaid members to receive up to six short-term behavioral health services provided by a licensed behavioral health clinician working as part of a member’s PCMP. These first six services are provided fee-for-service and are not covered by the RAEs. The trend shows varied usage across the course of the year with seasonal decreases and December of each calendar year.

The Department will continue to monitor the number of members utilizing fee-for-service behavioral health services to ensure that the decrease in December 2018 was part of the ongoing seasonal trend rather than the beginning of an overall decrease in member utilization.

For more information see: https://www.colorado.gov/pacific/sites/default/files/BH%20primary%20care%20fact%20sheet%2007.17.18.pdf
In the most recent month of data, December 2018, the percentage of members accessing fee-for-service behavioral health services in each region ranged from 0.86% in the Eastern Plains to 2.02% in Northwestern Colorado. This variation is consistent with expectations as various geographic and socio-economic factors impact member utilization, particularly in December 2018 when weather, seasonal travel, and temporary facility closures for the holidays may have had an impact.

The 2016 AMRP identified that HSR 16 (HRS grouping 5, Northern Colorado) and HSR 4 (HRS grouping 3, Colorado Springs/Pueblo) required monitoring after decreases in the utilization rates.

The data in this report shows that the utilization count in HSR 16 increased from 576 utilizers in January 2016 to 726 utilizers in December 2018, up from its high of 400 utilizers in January 2014. Utilization has increased since the previous Plan, with a spike in July 2018 following a policy change that increased fee-for-service behavioral health service usage. While this change in policy saw a larger increase in children receiving fee-for-service behavioral health services, this increase in utilization since the previous Plan can be seen equally across all demographic groups.

Utilization in HSR 4 increased from 1,378 utilizers in January 2016 to 2,393 utilizers in December 2018, up from its high of 1150 in January 2014. There has been a significant increase in utilization in the current reporting period.

The Department also looked at access to behavioral health services in HSRs 16 and 4 through its Rate Review process. The 2019 Rate Review Analysis report looked at access to fee for service behavioral health through a number of metrics including utilizer density and penetration rate. HSR 16 had a slightly lower density and penetration rate than neighboring HSRs. HSR 4 had one of the highest utilizer densities in the state and a relatively high penetration rate.
The number of providers delivering fee-for-service behavioral health services to Colorado Medicaid members increased from 1,529 in January 2016 to 1,774 in December 2018.

The decrease observed in March of 2017 is artificial. It coincides with the roll-out of a new Medicaid Management Information System (interChange) and the requirement that providers re-enroll as Colorado Medicaid providers within the new system.

Since the data system change, the number of providers has steadily increased with minor variations in most regions. As with utilizor data, it appears that there was a seasonal decrease in the number of providers delivering services in December of each year.
The penetration rate followed similar trends across all seven regions. There was a significant peak in utilization from July 2018 when the first six-visits fee-for-service policy change was introduced. The overall percentage of members accessing services increased over time.

**Behavioral Health Services Health Professional Shortage Areas**

Primary care, dental, and mental health Health Professional Shortage Areas (HPSAs) are designated, scored and monitored by the Health Resources and Services Administration (HRSA). HPSAs may be geographic-, population-, or facility-based. Geographic shortages relate to the entire population within a defined area and population shortages relate to a shortage of provides for a specific population in a geographic area (such as low-income, migrant farmworkers and other groups). Colorado does not have any specific Medicaid Eligible Population HPSAs.

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46 Source: HSRA. For more information on HSPAs, see: [https://bhw.hrsa.gov/](https://bhw.hrsa.gov/)

47 State Primary Care Offices submit applications to designate all HPSAs – in Colorado this is the Colorado Department of Public Health and Environment. HRSA reviews applications to determine if they meet the eligibility criteria for designation. The main eligibility criterion is that the proposed designation meets a threshold ratio for population to providers. Once designated, HRSA scores HPSAs on a scale of 0-25 for primary care and mental health, and 0-26 for dental health, with higher scores indicating greater need.
In Colorado there are currently nine mental health geographic HPSAs crossing 54 of Colorado’s 64 counties. It is important to note that geographic HPSAs relate to the entire population of that region, not just the Medicaid population. Of these, 44 counties have a rating in the mid-range and 12 are classified as having a greater need with a rating of 19/25 or higher. Those areas with scores on the higher end of the scale have been identified as having the greatest priority for assigning clinicians and addressing professional shortages through various federal and state government initiatives such as loan waiver programs. Areas with higher scores are also eligible to have clinics in that location deemed Rural Health Clinics by the Centers for Medicare and Medicaid Services (CMS), providing enhanced reimbursement. HPSA data indicates that access to care to behavioral health services can be improved across most areas of the state.

The Department has been working with the Colorado Department of Public Health and Environment (CDPHE) on building a repository that better monitors and tracks Colorado Medicaid provider enrollment compared to overall provider availability. Initial data collected by CDPHE using this tool in August-October 2018 shows that for most of the state, Colorado Medicaid member access (measured through provider availability) is comparable to other Coloradans’ access.

While the definitions of behavioral health provider vary slightly from those used in this plan (which includes a larger definition of providers), this map may present a more accurate
representation of Colorado Medicaid member access to behavioral health services than the data used in this Plan as it utilizes multiple agency data sources and can compare provider availability with other payer types in the same geographic area.

Figure 42 – Number of Behavioral Health Providers (Medicaid) by County and as a Percent of all Behavioral Health Providers

In 27 of Colorado’s 64 counties, the number of Medicaid behavioral health providers was at least 30% of the total number of providers available, this is a greater representation than the total Medicaid population in the state (23.1%). An additional 15 counties have Medicaid behavioral health providers representing between 23-30% of the total providers, in line with the total Medicaid population percentage.

While access to behavioral health services in the HPSAs can be improved, data from this plan and the Department’s Rate Review process demonstrate that the problem is not unique to Medicaid. The 2019 Rate Review Analysis report found an increase in the number of utilizers and providers across all regions of the state, including an increase in the number of providers in rural counties (where most HPSAs are located).
The picture in Colorado is consistent with national trends of behavioral health professional shortages. Recent HSRA behavioral health workforce projections showed significant national shortages for qualified behavioral health professionals which is exacerbated by high turnover rates, a lack of professionals, aging workers and low compensation\(^{48}\). The Department continues to work on provider recruitment and retention. Recent Department policy changes have seen an increase in the number of members who have been able to access behavioral health services over the past year.

The Colorado Department of Human Services also has workforce development programs in place for behavioral health workers. These programs aim to not only improve competency but to support employee retention.

The RAE quarterly Provider Network Adequacy reports provide further information on the adequacy of the Department’s behavioral health networks. The most recent reports (Quarter 3 2018-2019) show that behavioral health networks across the state are sufficient for member access on key foundational metrics. For example:

- In RAE 1 96% of all behavioral health facilities were accepting new members;
- In RAE2, 99% of members had access to at least two behavioral health providers within the time and distance standard maximums;
  In RAE3, the member to provider ratio standard (1:1,800) was significantly exceeded, with the RAE reporting a ratio of 1:338; and
- In RAE4, the RAE expanded telemedicine availability for members in rural and frontier counties when members identified transportation barriers for accessing care.

The Department is actively monitoring these reports and working in collaboration with key stakeholders, including the Centers for Medicare and Medicaid Services (CMS), to identify and optimize network adequacy and performance.

In the map above, primary care providers providing behavioral health services were excluded, leaving only licensed behavioral health professionals. More than 98.05% of Colorado Medicaid members live within 30 minutes’ drive time of a fee-for-service behavioral health provider. An additional 1.10% live within 30 to 45 minutes’ drive of a provider, and 0.52% within an hour. Most areas where the remaining 0.32% of members live (more than an hour away from their nearest fee-for-service behavioral health provider) are regions where the terrain is less accessible, primarily due to mountain ranges.

49 This is a measure of potential access. The Department continues to improve its data capability and may include maps of realized access (e.g. where members actually received services in relation to their residence) in future iterations of this Plan.
As primary care providers are able to deliver routine fee-for-service behavioral health services, and because they may be the only behavioral health provider in rural and remote communities, the Department also measured drive time to a fee-for-service behavioral health provider when primary care providers who provide such services are included. The change that this had on drive time was not significant (increasing from 98.05% of members within 30 minutes to 98.98%) indicating that while access is improved when primary care providers are able to deliver behavioral health services, most members are within a similar drive time to a qualified fee-for-service behavioral health professional.
Behavioral Health Services Rate Comparison

It is important to note that most behavioral health services are delivered under a capitated benefit paid to RAES. RAES negotiate behavioral health reimbursement rates with the providers in their network; these payments are not considered in this analysis.

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<thead>
<tr>
<th>Reimbursement Type</th>
<th>Aggregate Percentage Fee-For-Service Behavioral Health Medicaid Rate Comparison</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>60.10%</td>
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<td>Arizona Medicaid</td>
<td>70.70%</td>
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<td>California Medicaid</td>
<td>75.93%</td>
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<tr>
<td>Wyoming Medicaid</td>
<td>55.9%</td>
</tr>
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</table>

*Table 5 – Fee-For-Service Behavioral Health Medicaid Rate Comparison to Other Payment Types, Aggregate Percentage*

The Department compared 2018 Colorado Medicaid fee-for-service behavioral health services reimbursement rates with four other payers: Medicare; the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid. The Department limited its comparison to codes currently being utilized – and this resulted in seven codes being compared.

In aggregate, Colorado Medicaid’s fee-for-service behavioral health reimbursement rates were lower than the rates paid to fee-for-service behavioral health providers in California, Wyoming and Arizona. In aggregate, Colorado Medicaid fee-for-service behavioral health services reimbursement rates were at 60% of Medicare rates.

The Department also reviewed fee-for-service behavioral health services reimbursement rates in 2019 through the Rate Review process in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. The 2019 Rate Review Analysis report reviewed fee-for-service Behavioral Health Services and both Residential Child Care Facilities (RCCF) and Psychiatric Residential Treatment Facilities (PRTF). The Rate Review analysis considered a much larger set of codes than this Plan, and also compared RCCF and PRTF separately.

The 2019 report found that the 33 fee-for-service behavioral health procedure codes it reviewed were at 94.67% of the benchmark (which, in most cases, was Medicare; where Medicare was not an appropriate comparator, the benchmark was an average of seven comparable Medicaid states). For individual procedure codes this varied from 42.57% of Medicare rates to 244.63%. The 2019 Rate Review also compared rates to the 2019 Colorado Medicaid Physician Fee Schedule – a different time period of comparison than used in this report. The RCCF procedure code was compared separately in the 2019 Rate Review report and was found to be at 68.56% of the benchmark.

While the Medicare rate comparison varies between this report and the 2019 Rate Review report, the differences in findings can be attributed to a difference in methodology (including comparing RCCFs separately) and measurement tools, the Rate Review process assessing a
larger set of behavioral health codes, as well as fee schedule differences between 2018 and 2019.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare.50

Behavioral Health Services Input from Beneficiaries, Providers, and Stakeholders

The Department reviewed fee-for-service behavioral health service rates through the Rate Review process in 201951. No stakeholder feedback was received by the Department through this process.

Over the past three years, the Department has received feedback on access to specific fee-for-service behavioral health services in specific regions of the state or for specific populations. When the Department has received such requests, it has undertaken an evaluation. If adequate information to resolve a concern already existed, a change was implemented. If not, an evaluation design is created, and an analysis undertaken. Stakeholders are involved throughout the entire process – including informing the evaluation design and the analysis stage.

Public comment period comments to be inserted here

Additional Behavioral Health Services Access Analysis Planned as a Result of This Review

The Department will conduct ongoing monitoring of fee-for-service behavioral health utilization data through 2019 to ensure that decreases seen in December 2018 are part of the yearly seasonal trend rather than the beginning of a downward trend.

The Department plans a broader ongoing analysis of the impact of the 1 July 2018 policy change (allowing the first six behavioral health services to be billed fee-for-service), which increased fee-for-service behavioral health utilization, to ensure that members are able to appropriately access behavioral health services in a timely manner.

50 When Medicare is not an appropriate model, the Department 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 the Department views reimbursements between 80% - 100% of Medicare and reimbursements 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 reimbursements at a certain amount; investigating if a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies; identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and developing systems to ensure that reimbursements are associated with high-quality provision of services.

Pre- and Post-natal Obstetric Services
For full data workbook see – Appendix K – Pre- and Post-natal Obstetric Services Data Workbook

Definition of Service
Colorado Medicaid provides fee-for-service maternity services with risk-appropriate care that will ensure optimal maternal and child health outcomes. Services include early and continuous risk screening for pregnant women, early entry into prenatal care, prenatal care delivered by the provider/specialty level best suited to the risk of the member, labor and delivery services appropriate to member risk, and postnatal care as needed.
Characteristics of the Member Population

Figures 45 and 46 contain demographic information about those Colorado Medicaid members who utilized pre- and post-natal obstetric (PPNO) services (including labor and delivery) in calendar year (CY) 2018, including the number and age of service utilizers.

Nationally, the majority of pregnancies occur in women aged 20-39, in 2017 the birth rate was highest among women aged 30-34 (100.3 births per 1,000), 25-29 (98.0 births per 1,000), and 20-24 (71.0 births per 1,000)\(^52\). The age distribution pattern in Figure 45 is similar to the general distribution of pregnant women in the United States.

Pre- and Post-natal Obstetric Services Utilization Analysis by Geographic Region

Figure 47 – Pre- and Post-natal Obstetric Services Utilizer Count, by HSR Grouping

The number of Colorado Medicaid members utilizing fee-for-service pre- and post-natal obstetric services (including labor and delivery) across Colorado decreased between 2016 and 2018, from an average of 8,900 per month in 2016 to 8,600 per month in 2018. This is in line with the broader national trend of declining birth rates: the total number of births in the United States decreased by 2% from 2016 to 2017, and the general fertility rate also fell 3% during this time.\(^53\)

The trend shows varied usage across the course of the year with seasonal increases over summer months and decreases in December of each calendar year. This is in line with global data supporting seasonal reproduction trends\(^54\).

In the most recent month of data, December 2018, the percentage of female Colorado Medicaid members accessing pre- and post-natal obstetric services (including labor and delivery) in each region ranged from 1.17% in Northwestern Colorado to 1.92% in Metro Denver (North & East).


\(^54\) Source: Smithsonian. For more see: https://www.smithsonianmag.com/science-nature/more-babies-are-conceived-during-winter-fall-180971112/
Figure 48 – Pre- and Post-natal Obstetric Services Provider Count, by HSR Grouping

The number of providers delivering pre- and post-natal obstetric services (including labor and delivery) to Colorado Medicaid members decreased from 2,066 in January 2016 to 1,594 in December 2018.

The decrease observed in March of 2017 is artificial. It coincides with the roll-out of a new Medicaid Management Information System (interChange) and the requirement that providers re-enroll as Colorado Medicaid providers within the new system.

Since the data system change, the number of providers has remained relatively steady with minor variations in most regions.

While the decrease observed in March of 2017 is artificial, data indicates a slight decrease in providers post-2017. The decrease in providers is similar to the decrease in utilization, most likely explained by decreasing birth rates rather than an inability to access care. Pre- and post-natal obstetric services are generally always available to Colorado Medicaid members – regardless of provider levels – this is because labor and delivery services occur mainly in hospitals and these providers very rarely change.
The penetration rate was fairly consistent in all seven regions; however, there were some evident variations from the overall trend in the Northwestern Colorado region. The average penetration rate decreased from 1.79% in January 2016 to 1.66% in December 2018 and this is in line with lower utilization and decreasing birth rates.

The 2018 Rate Review Analysis report noted a decrease in provider levels and the penetration rate in HSRs 6 (HSR grouping 1, Eastern Plains) and 9 (HRS grouping 4, San Luis Valley) While initial access analyses in the were inconclusive, subsequent analysis indicated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) provide maternity services within these regions at a higher rate than in most other regions; FQHCs and RHCs in HSR 6 provide maternity services at a higher rate than in any other region of the state.  

In the 2018 Rate Review Recommendation report, the Department indicated it would include within this Plan additional data and analysis of access in HSR 9. Specifically, the Department would conduct county-specific investigations to determine if trends in one county are driving results for the entire region.

The penetration rate for HSR 9 (Archuleta, Dolores, La Plata, Montezuma and San Juan Counties, HRS grouping 4, San Luis Valley) decreased since the 2018 Rate Review report was published in May 2018, from 1.85% in May 2018 to 1.29% in December 2018. The decrease is in line with yearly seasonal trends and decreases across other regions of Colorado. The number of providers in HSR 9 during this same period decreased from 50 providers in April 2018 to 41 in December 2018.

When data was examined at the county level it was found that a significant decrease in utilization in La Plata county was driving the decrease in penetration rate. The number of women accessing services decreased by almost 40% while provider levels remained relatively steady. This decrease in utilization led to a decrease in the penetration rate in La Plata from 1.73% in January 2016 to 0.97% in December 2018. Delores and Montezuma counties both saw an increase in penetration rate, likely driven by increased member utilization, with the number of providers also increasing in Delores county.

The Department is also working with the Colorado Department of Public Health and Environment and their Health Systems Directory project to understand if the number of providers in HSR 9 varies based on insurance type. This will allow the Department to determine if any potential issue is specific to Medicaid or the region as a whole. This work is currently being undertaken and will inform future Department access work.
Pre- and Post-natal Obstetric Services Drive Time Mapping\textsuperscript{56}

![Map of drive time mapping](image)

*Figure 50 – Pre- and Post-Natal Obstetric Services Drive Time Mapping – Potential Access*

More than 98.40\% of fee-for-service Colorado Medicaid members live within 30 minutes’ drive time of a pre- and post-natal obstetric services provider. An additional 0.99\% live within 30 to 45 minutes’ drive of a provider, and 0.39\% within an hour. Most areas where the remaining 0.20\% of members live (more than an hour away from their nearest pre- and post-natal obstetric service provider) are regions where the terrain is less accessible, primarily due to mountain ranges.

\textsuperscript{56} This is a measure of potential access. The Department continues to improve its data capability and may include maps of realized access (e.g. where members actually received services in relation to their residence) in future iterations of this report.
Pre- and Post-natal Obstetric Services Rate Comparison

<table>
<thead>
<tr>
<th>Reimbursement Type</th>
<th>Aggregate Percentage Pre- and Post-natal Obstetric Medicaid Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>65.87%</td>
</tr>
<tr>
<td>Arizona Medicaid</td>
<td>74.33%</td>
</tr>
<tr>
<td>California Medicaid</td>
<td>106.92%</td>
</tr>
<tr>
<td>Wyoming Medicaid</td>
<td>64.57%</td>
</tr>
</tbody>
</table>

*Table 6 – Pre- and Post-natal Obstetric Medicaid Rate Comparison to Other Payment Types, Aggregate Percentage*

The Department compared 2018 fee-for-service Colorado Medicaid pre- and post-natal obstetric services (including labor and delivery) reimbursement rates with four other payers’: Medicare; the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid.

In aggregate, Colorado Medicaid’s pre- and post-natal obstetric services (including labor and delivery) reimbursement rates were slightly higher than the rates paid to pre- and post-natal obstetric services providers in California. The aggregate percentage was lower than the rates paid in Arizona and Wyoming; however, Wyoming services a much smaller Medicaid population with only 55,000 members receiving Medicaid as of March 2019. In aggregate, Colorado Medicaid pre- and post-natal obstetric services (including labor and delivery) reimbursement rates were at 65.87% of Medicare rates.

The Department also reviewed select maternity service reimbursement rates in 2018 through the Rate Review process in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. The 2018 Rate Review report found that maternity services rates in Colorado were at 69.49% of the benchmark. Medicare covers certain maternity services for individuals under 65 years old who qualify for Medicare due to disability; however, because the population eligible for Medicare maternity services is considerably different from the population eligible for Colorado Medicaid’s maternity services, the Department compared exclusively to other states’ Medicaid rates (Arizona, Nebraska, Oklahoma, Oregon, and Wyoming). These results largely align with the findings above. Differences in findings can be attributed to a difference in methodology, and measurement tools (including the number of other states compared to).

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare.57

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57 When Medicare is not an appropriate model, the Department 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 the Department views reimbursements between 80% - 100% of Medicare and reimbursements 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 reimbursements at a certain amount; investigating if a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies; identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and developing systems to ensure that reimbursements are associated with high-quality provision of services.
The 2018 Rate Review report found that while rates were sufficient to allow for member access and provider retention, rates were below 80-100% of the other comparator states and recommended that rates be increased to no more than 80% of the benchmark. In the most recent budget cycle, the Department secured an additional $4 million in funding for maternity services.

As the largest insurer of pregnant women in the state, the Department believes that the best long-term approach to increasing reimbursement for maternity services is through a quality incentive and value-based payment lens. The Department has begun an analysis of value-based purchasing for maternity services to investigate whether moving to this model would further improve access to and quality of maternal health care for Colorado Medicaid members.

Pre- and Post-natal Obstetric Services Input from Beneficiaries, Providers, and Stakeholders

The Department reviewed fee-for-service maternity service rates through the Rate Review process in 2018\(^{58}\). No stakeholder feedback was received by the Department through this process.

In the past three years, the Department has received feedback on access to specific pre- and post-natal obstetric services in specific regions of the state or for specific populations. When the Department has received such requests, it has undertaken an evaluation. If adequate information to resolve a concern already existed, a change was implemented. If not, an evaluation design is created, and an analysis undertaken. Stakeholders are involved throughout the entire process – including informing the evaluation design and the analysis stage.

Public comment period comments to be inserted here

Additional Pre- and Post-Natal Obstetric Services Access Analysis Planned as a Result of This Review

The Department plans to undertake additional analysis on the following:

- Value-based payment models for improving quality of pre- and post-natal obstetric care (including labor and delivery)
- Provider availability by insurance type in HSR 9 (with the Colorado Department of Public Health and Environment)

The Department will also conduct ongoing monitoring of pre- and post-natal obstetric care (including labor and delivery) utilization data through 2019 to ensure that decreases seen in

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\(^{58}\) Source: 2018 Medicaid Provider Rate Review Analysis Report. For more see:
December 2018 are part of the yearly seasonal trend rather than the beginning of a bigger downward trend, outside of falling national birth rates.
Home Health Services
For full data workbook see – Appendix L – Home Health Services Data Workbook

Definition of Service
Home Health Services consist of skilled nursing, certified nurse aide (CNA), physical (PT) and occupational therapy (OT), and speech/language pathology (SLP) services. Home Health is a mandatory State Plan benefit offered to Colorado Medicaid members who need intermittent skilled care. Individuals that render home health services must be employed by a licensed, class A Home Health agency. Home health services are divided into two service types: acute and long-term. Acute home health services are provided for treatment of acute conditions and episodes (e.g. post-surgical care) for up to 60 days. Long-term home health services are available to members who require ongoing home health services beyond the 60-day acute home health period.

Additional in-home services, which are part of the necessary continuum of care for technology-dependent Colorado Medicaid members, are provided under other benefits such as the Private Duty Nursing benefit. Private Duty Nursing (PDN) means face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility. Colorado Medicaid members who meet both the eligibility requirements for PDN and home health are allowed to choose whether to receive care under PDN or under the home health benefit. Members may choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the member.
For the purposes of this report, the services analyzed are limited to those provided under the home health benefit.

Characteristics of the Member Population
Long-term home health services require prior authorization. For members aged 20 years and younger, prior authorization requires: an acuity assessment, conducted via the Pediatric Assessment Tool (PAT); the member’s home health orders; plan of care; and supporting documentation. For members aged 21 years and older, prior authorization requirements include meeting criteria outlined in the home health portion of the Colorado Code of Regulations and meeting Long-Term Care 100.2 criteria. Through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, members aged 20 years and younger may receive PT, OT and SLP in both acute and long-term home health service periods, while members aged 21 years and older may only receive PT, OT and SLP home health services for acute periods.

Figures 51, and 52 contain demographic information about those Colorado Medicaid members who utilized home health services in calendar year (CY) 2018, including the number, age and gender of service utilizers.

The age and disability distribution pattern in Figure 51 is different from the general distribution of all Colorado Medicaid program members in CY 2018. Home health services are required by a smaller subset of the Colorado Medicaid population, and are generally required by those with either a long-term disability or an acute episode (for example post-surgery). As such, a higher percentage of individuals with a disability utilized the services compared to other service categories. The age distribution also differs from other categories. The two largest utilizer categories were pediatric and those aged 50 and older, with far fewer members aged 18-49 utilizing this benefit.
The number of Colorado Medicaid members utilizing fee-for-service home health services increased between 2016 and 2018, from an average of 10,600 per month in 2016 to an average of 12,500 per month in 2018. The trend shows consistent usage across the course of the year with none of the seasonal decreases seen in other service categories.

In the most recent month of data, December 2018, the percentage of members accessing home health services in each region ranged from 0.26% in Northwestern Colorado to 1.55% in Metro Denver (North & East). This variation is consistent with expectations as utilization is generally higher in the more populous regions of the state, where travel times for providers are lower and family/in-home caregiving occurs more frequently.
The number of providers delivering home health services to Colorado Medicaid members increased from 151 in January 2016 to 178 in December 2018. Note: the number of providers appears small as home health services are generally measured by the number of home health agencies, and not the number of employees (such as nurses and home health aides) in each agency delivering on the ground services.

In the last few years, larger state-wide or national organizations have purchased smaller local home health agencies. Subsequently, the number of providers enrolled decreased in some regions. However, the overall number of people delivering services on the ground has remained the same.

The penetration rate has largely increased in six of the seven regions since January 2018. However, there was a small decrease in the San Luis Valley region (0.68% to 0.55%) which the Department will monitor to ensure member access is not being impacted.

Home Health Services Care Rate Comparison

<table>
<thead>
<tr>
<th>Reimbursement Type</th>
<th>Aggregate Percentage Home Health Medicaid Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medicaid</td>
<td>122.64%</td>
</tr>
<tr>
<td>California Medicaid</td>
<td>104.59%</td>
</tr>
<tr>
<td>Wyoming Medicaid</td>
<td>81.91%</td>
</tr>
</tbody>
</table>

Table 7 – Home Health Medicaid Rate Comparison to Other Payment Types, Aggregate Percentage

The Department compared 2018 fee-for-service Colorado Medicaid home health service reimbursement rates with three other payers: the Arizona Health Care Cost Containment System (Arizona’s Medicaid Program), the California Medical Assistance Program (California’s Medicaid Program); and Wyoming Medicaid.

A comparison with Medicare rates was not undertaken for this report. The Department’s analysis is that Medicare’s Low Utilization Payment Adjustment (LUPA) rate is not an appropriate comparator rate. Reasons include, but are not limited to, differences in:

- Client eligibility: Medicare clients must be confined to the home to receive home health services; Colorado Medicaid clients are not.
• Utilizer characteristics: Medicare provides services for the elderly, while Colorado Medicaid provides home health services to other populations, including children and adults, who have different diagnoses and health care needs.
• Unit designations: Colorado Medicaid has some tiered reimbursements based on visit type, Medicare does not.

In aggregate, Colorado Medicaid’s home health services reimbursement rates were slightly higher than the rates paid to home health services providers in California and significantly higher than Arizona. The aggregate percentage was lower than the rates paid in Wyoming; however, Wyoming services a much smaller Medicaid population with only 55,000 members receiving Medicaid as of March 2019.

The Department reviewed home health services reimbursement rates in 2016 through the Rate Review process in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. The 2016 Rate Review report reviewed home health Services consisting of skilled nursing, certified nurse aid (CNA), physical therapy (PT), occupational therapy (OT), and speech/language pathology (SLP) services. The Rate Review found that, in aggregate, home health rates were sufficient to allow for provider retention and that rates supported growth in utilization of services.60 Home health service payments were between 72.49% and 197.11% of other state Medicaid rates. The Department found that rates were sufficient for access and recommended leaving rates unchanged and investigating what a switch from visit-based payments to unit-based payments would entail.

While the Medicaid rate comparison varies between this report and the 2016 Rate Review report, the differences in findings can be attributed to a difference in methodology and measurement tools (including comparing with different states such as Illinois, Ohio & Nebraska), as well as fee schedule differences between 2015 and 2018. The Department has also recently begun reviewing home health reimbursement rates again as part of the Rate Review Process and will report its findings in 2020.

Home Health Services Input from Beneficiaries, Providers, and Stakeholders

The Department reviewed home health service rates through the Rate Review process in 201661. Stakeholder feedback received during this process regarded provider retention: stakeholders indicated that home health agencies had difficulty recruiting and retaining staff and attributed this difficulty, in part, to competition with hospitals that offer better wages and benefit packages. It was suggested that increased rates would aid recruiting and ease retention issues.

The Rate Review analysis found that the rate benchmark and an increase in utilization meant that provider retention issues were more likely attributed to other causes, such as home health agency operational differences, licensure requirements, or other non-fiscal constraints. The findings in this report support that conclusion as utilization and provider counts have generally increased across the state over the last three years.

*Public comment period comments to be inserted here*

Additional Home Health Access Analysis Planned as a Result of This Review

The Department plans to undertake access analysis on the following:
- Access to home health services in the San Luis Valley region, including member utilization and provider counts.
- Home Health service rates through the 2020 Rate Review process
Access to Care for Fee-For-Service Colorado Medicaid Members

The Department has investigated and analyzed access to the five service categories in this Plan for fee-for-service benefits for Colorado Medicaid Members.

While measuring access to care is challenging and no one measure can accurately report on the sufficiency of access to care, the Department has found that access to Primary Care, Physician Specialty, fee-for-service Behavioral Health, Pre- and Post-natal Obstetric (including labor and delivery) and Home Health services is sufficient, as defined by 42 CFR 447.203. Colorado Medicaid members are able to access care to a similar extent as other Coloradans in the same geographic area and data analyzed over the past three years is trending in the appropriate direction.

Members were able to access services as anticipated from January 2016 through December 2018. In most regions, and for all but one service category, the number of utilizers and active providers has either trended steady or increased. Taken together, these metrics indicate a positive trend for access sufficiency. Pre- and post-natal obstetric services experienced a decrease in utilization and active providers; however, this appears to be in line with the national trend of decreasing birth rates rather than an inability of members to access services.

There are some regions of the state (such as the San Luis Valley) for which the data indicates a need for ongoing monitoring; however, data does not indicate an access issue at this time.

This finding does not discount that individual members may experience challenges when accessing specific services in specific regions of the state. This analysis evaluates access at the service grouping level; evaluation of access to specific services is outside the scope of this report. The Department has many programs and processes in place to evaluate and improve access to care for members at the population, regional, and service-specific level and takes all feedback on potential access challenges seriously. To learn more, visit the Department’s Access to Care website.

The Department is committed to monitoring and improving access to care for Health First Coloradans.

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62 Fulfills requirements 42 CFR 447.203(b)(1)(i) and 42 CFR 447.203(4)