MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Members of the Joint Budget Committee
FROM	Robin J. Smart, JBC Staff (303-866-4955)
DATE	November 15, 2022
SUBJECT	Medicaid Provider Rate Review Schedule

Under current law [Section 25.5-4-401.5, C.R.S.], the Department of Health Care Policy and Financing must review Medicaid provider rates based on a schedule that allows for the review of each provider rate at least every five years. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) or the Joint Budget Committee (JBC), by majority vote, may direct the Department to conduct a review of a provider rate not scheduled for review during a given year, or to include an exempted rate in the review. If the JBC requests a rate review, it must notify the Department of the out-of-cycle rate review by December 1st.

REVIEW PROCESS

The Department's periodic rate reviews are conducted with input from the MPRRAC and are intended to inform the Governor's annual budget request and the General Assembly's deliberations concerning Department appropriations. The Department may exempt rates from review because the rates are adjusted periodically based on costs, adjusted periodically based on another state or federal law or regulation, or are payments unrelated to a specific service rate. As part of the review, the Department must:

- Compare Medicaid rates to available benchmarks
- Use metrics to assess whether payments are sufficient to allow provider retention and client access and to support appropriate reimbursement of high-value services

Rate adjustments are not guaranteed in the year a rate is reviewed for two reasons: 1) the rate review process and rate adjustments take place over several years (for example, rates adjustments related to those rates reviewed in calendar year 2021, if requested, will be included in the November 1, 2022 budget request to go into effect July 1, 2023); and 2) any rate adjustments are dependent upon available State resources. The Department is required to work with the Office of State Planning and Budgeting to determine achievable goals and Executive Branch priorities within the statewide budget. Through the annual budget process the Department can ask for adjustments to rates that were reviewed in prior years. The Department just completed Year 2 of the Second Five-Year Review Cycle, including:

- Physician Services
- Dialysis and Nephrology
- Eyeglasses and Vision
- Laboratory and Pathology
- Injections and Miscellaneous J-Codes

The Department submitted the Medicaid Provider Rate Review Analysis Report to the JBC on May 2, 2022. The report contains analyses, rate comparisons, and sufficiency assessments for the sets of services identified above. Recommendations are summarized in the Recommendation Report submitted on November 1 2022. Links to these reports can be found here: Rate Review Reports | Colorado Department of Health Care Policy & Financing

MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE

MPRRAC is a statutorily created advisory committee responsible for assisting the Department in the review of Medicaid provider rate reimbursements. It is required to meet at least once every quarter and, during the most recent rate review process, consisted of 24 members, 6 of whom were appointed by each of the following: the President of Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives, and the Minority Leader of the House of Representatives. **Please see below for information concerning changes to the committee size and the rate review process.**

SUMMARY OF DEPARTMENT RECOMMENDATIONS

In year two of the second five-year review cycle, which occurred during calendar year 2021, the rates identified below were analyzed. In general, for all reviewed services, the Department recommends increasing rates for services that are below 80 percent of the benchmark rates to 80 percent of the benchmark rate and decreasing rates for services above 100 percent of the benchmark rate to 100 percent of the benchmark rate.

The MPRRAC report indicates that the Department estimates implementation of the recommendations identified in the summary report as costing $41.4 million total funds, including $12.4 million General Fund in FY 2023-24. The Department has requested funding for the recommendations in its FY 2022-23 R7 Provider Rate Adjustments budget request. These requested rate adjustments will be discussed during the JBC staff briefing on December 2, 2022. It is important to note that the rate adjustments identified in the Department's annual budget request for targeted provider rate adjustments may not always reflect all of the recommendations found in the annual Recommendation Report.

- **PHYSICIAN SERVICES:** Unless otherwise indicated, the Department recommends rebalancing rates in each category by increasing those rates identified to be below 80 percent of the benchmark to 80 percent of the benchmark and decreasing rates identified to be over 100 percent of the benchmark to 100 percent of the benchmark.
    - *CARDIOLOGY* – The Department found that payment rate for cardiology services was 90.7 percent of the benchmark and that Colorado payments varied between 35.0 and 358.1 percent of Medicare and an average of two other states' Medicaid rates (Nevada and Oregon).
    - *COGNITIVE CAPABILITIES ASSESSMENT* – The Department found that payment rate for cognitive capabilities assessment services was 127.2 percent of the benchmark and that Colorado payments varied between 69.0 and 378.7 percent of Medicare and an average of six other states' Medicaid rates (Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon).
    - *EAR, NOSE, AND THROAT (ENT)* – The Department found that payment rate for ENT services was 76.4 percent of the benchmark and that Colorado payments varied between 5.4 and 835.4 percent of Medicare and an average of three other states' Medicaid rates (Arizona, Oklahoma, and Oregon).
    - *GASTROENTEROLOGY* – The Department found the payment rate for gastroenterology services was 63.5 percent of the benchmark and that Colorado payments varied between 20.6 and 107.9 percent of Medicare.
    - *HEALTH EDUCATION* – The Department found the payment rate for health education services was 62.4 percent of the benchmark and that Colorado payments varied between

51.3 and 1,058.2 percent of Medicare and an average of five other states' Medicaid rates (Arizona, Oklahoma, Utah, Nevada, and Oregon).

- *OPHTHALMOLOGY* – The Department found the payment rate for ophthalmology services was 78.2 percent of the benchmark and that Colorado payments varied between 12.2 and 331.2 percent of Medicare and an average of six other states' Medicaid rates. In addition to rebalancing the ophthalmology rates, the Department recommends maintaining codes with a GT modifier (used to identify claims for services via interactive audio and video telecommunications systems) over 100 percent of the benchmark at the current rate; and educating providers on appropriate codes for highly specialized and custom services.
- *PRIMARY CARE/EVALUATION AND MANAGEMENT (E&M)* – The Department found the payment rate for primary care/E&M services was 83.2 percent of the benchmark and that Colorado payments varied between 37.3 and 194.0 percent of Medicare and an average of six other states' Medicaid rates.
- *RADIOLOGY* – The Department found the payment rate for radiology services was 90.6 percent of the benchmark and that Colorado payments varied between 9.5 and 389.0 percent of Medicare and an average of six other states' Medicaid rates.
- *RESPIRATORY* – The Department found the payment rate for respiratory services was 97.5 percent of the benchmark and that Colorado payments varied between 39.9 and 141.8 percent of Medicare and an average of six other states' Medicaid rates.
- *VACCINES AND IMMUNIZATION* – The Department found the payment rate for vaccines & immunization services was 107.9 percent of the benchmark and that Colorado payments varied between 36.8 and 284.7 percent of Medicare and an average of six other states' Medicaid rates. The Department recommends increasing vaccine and immunization rates that were identified to be below 80 percent of the benchmark to 80 percent of the benchmark and leaving rates that were identified to be above 80 percent of the benchmark at the current rate.
- *VASCULAR* – The Department found the payment rate for vascular services was 121.2 percent of the benchmark and that Colorado payments varied between 48.4 and 310.7 percent of Medicare and an average of six other states' Medicaid rates. The Department will use the rebalancing of rates to identify the services that would benefit from an immediate rate change.
- *WOMEN'S HEALTH AND FAMILY PLANNING* – The Department found the payment rate for women's health and family planning services was 83.4 percent of the benchmark and that Colorado payments varied between 36.3 and 194.3 percent of Medicare and an average of six other states' Medicaid rates. In addition to rebalancing the women's health and family planning rates, the Department recommends maintaining codes with the GT modifier over 100 percent of the benchmark at the current rate and increasing evaluation and management rates with the family planning services (FP) modifier rates to align with the same services paid to other provider types. The Department will use the rebalancing of rates to identify services that would benefit from an immediate rate change.
- *OTHER PHYSICIAN SERVICES* – The Department found the payment rate for other physician services was 83.7 percent of the benchmark and that Colorado payments varied between 4.0 and 429.4 percent of Medicare and an average of six other states' Medicaid rates.

- **DIALYSIS AND NEPHROLOGY SERVICES**: The Department recommends increasing dialysis facility-based services rates and professional services rates to 80 percent of the benchmark and

will continue to work to identify the correct primary payer and help facilitate the billing of the correct payer.

  - *FACILITY-BASED PAYMENTS* – The Department found the payment rate for dialysis facility-based services was 78.5 percent of the benchmark and that Colorado payments varied between 75.5 and 80.2 percent of Medicare regional rates.
  - *PROFESSIONAL PROCEDURE CODES ANALYSES* – The Department found that the payment rate for dialysis professional services was 61.1 percent of the benchmark and that Colorado payments varied between 26.9 and 104.0 percent of Medicare and an average of three other states' Medicaid rates (Arizona, Nevada, and Oregon).

- **LABORATORY AND PATHOLOGY SERVICES**: The Department found the payment rate for laboratory and pathology (laboratory) services was 93.7 percent of the benchmark and that Colorado payments varied between 6.9 and 178.3 percent of Medicare and an average of seven other states' Medicaid rates (Arizona, California, Oklahoma, Nebraska, Utah, Nevada, and Oregon). The Department recommends rebalancing laboratory service rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark.
- **EYEGLASSES AND VISION SERVICES**: The Department found the payment rate for eyeglasses & vision (vision) services was 57.4 percent of the benchmark and that Colorado payments varied between 14.0 and 192.0 percent of Medicare and an average of six other states' Medicaid rates. The Department recommends rebalancing vision service rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark; and increasing eyeglasses and frames rates for children and adults who have had a qualifying surgery to 80 percent of the benchmark.
- **INJECTIONS AND MISCELLANEOUS J-CODES:** The Department found the payment rate for injections and miscellaneous J-codes was 95.6 percent of the benchmark and that Colorado payments varied between 5.0 and 184.9 percent of Medicare and an average of four other states' Medicaid rates (California, Nebraska, Utah, and Oregon). The Department recommends rebalancing injection and miscellaneous J-code rates that were identified to be below 80 percent of the benchmark and above 100 percent of the benchmark.
- **PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (PT/OT/ST):** In November 2021, the Joint Budget Committee (JBC) requested an out-of-cycle rate review of outpatient PT/OT/ST rates and asked for a comparison between outpatient and home health rates in each category. During the FY 2022-23 budget process, the JBC approved an increase in outpatient rates below 80 percent of the benchmark to 80 percent of the benchmark. The Department indicates that the outpatient rates were rebalanced as of July 1, 2022 and that all home health PT/OT/ST rates were above the 80 percent benchmark rate. The Department will continue to investigate opportunities to align rate reimbursement methodologies across similar services.
- **OUTPATIENT HOSPITAL SPECIALTY DRUGS:** In November 2021, the JBC requested an out-of-cycle rate review of outpatient hospital specialty drugs. The Department has implemented an increase to the reimbursement methodology for these drugs from 72 percent to 90 percent of the hospital's invoice net of rebates and discounts.

UPCOMING CHANGES TO THE RATE REVIEW PROCESS

During the 2022 Legislative Session, the Joint Budget Committee sponsored S.B. 22-236 (Review of Medicaid Provider Rates) in order to make changes to the Medicaid provider rate review process. The

bill requires implementation of the following provisions related to the Department of Health Care Policy and Financing's Medicaid rate reviews:

- Effective December 1, 2022:
  - The number of MPRRAC members is reduced from 24 to 7 members who are required to have proven expertise related to Medicaid in one or more specific areas.
  - Initial appointments to the committee are required no later than January 1, 2023, with the first committee meeting held on or after March 1, 2023. The MPRRAC's current sunset date of September 1, 2025, is moved to September 1, 2036.
- Effective September 1, 2023:
  - The Department must modify its existing five-year Medicaid provider rate review schedule to a three-year schedule and provide the schedule to the MPRRAC and the JBC.
  - If the Department determines a request from the MPRRAC or the JBC for an out-of-cycle review cannot be conducted, the Department must provide the requestor with written notification within 30 days after the request is made stating its reasons.
  - The Department must conduct a public meeting at least quarterly to inform its review of provider rates and submit a description and the Department's response as part of its reporting.
- On or before December 1, 2023, and each December 1 thereafter, **the MPRRAC must present to the JBC an overview of the provider rate review process, a summary of the provider rates that were reviewed, and the strategies for responding to the findings of the provider rate review**.
- On or before November 1, 2025, and each November 1 thereafter, the Department must submit a written report to the JBC and the MPRRAC on its rate analysis, a description of the information discussed during the quarterly meeting, and its recommendations. The May 1st analysis report is no longer required beginning in 2024.

The following table identifies some of the significant changes to the provider rate review process and timeline pursuant to S.B. 22-236.

MEDICAID PROVIDER RATE REVIEW
CHANGES PURSUANT TO S.B. 22-236

REQUIREMENT	DEADLINE	NOTES
New MPRRAC members appointed to 7-member advisory committee	January 1, 2023	The 3-year rate review schedule is not required to be created until May 1, 2023, therefore during 2023 the 7-member MPRRAC and the Department are still reviewing rates under the 5-year review schedule.
Department performs out of-cycle rate review requested by JBC or MPRRAC by December 1, 2022 and for rate recommendations that will be made in the 2024 report	during 2023	The out-of-cycle rate review request must be made by December 1st of the year prior to the year in which the rate review process will take place. A request made by December 1, 2022 will result in an out-of-cycle rate review taking place during 2023 and included in the report submitted November 1, 2024.
Last year for the review of provider rates under the 5-year rate review schedule	January 1, 2023 through December 31, 2023	The analysis and recommendation report concerning targeted provider rate adjustments resulting from the 2023 rate review process will be due November 1, 2024.
1st quarterly 7-member MPRRAC meeting	On or after March 1, 2023	The first quarterly meeting of the 7-member MPRRAC must occur on or after March 1, 2023.
Department must create the new 3-year rate review schedule	May 1, 2023	While the 3-year rate review schedule must be created by May 1, 2023, it is expected that the first year of rate review under the

MEDICAID PROVIDER RATE REVIEW CHANGES PURSUANT TO S.B. 22-236		
REQUIREMENT	DEADLINE	NOTES
		new 3-year cycle will occur during 2024, in order to avoid a year during which no rate review takes place.
Analysis report due to JBC/MPRRAC	May 1, 2023	The last May 1st analysis report will be due on May 1, 2023 concerning the review of rates that took place during 2022.
Department begins conducting rate review process public meetings	July 1, 2023	The initial year of public meetings (required as of July 1, 2023) will concern rates reviewed in 2023 under the 5-year cycle.
Department submits provider rate recommendation report	November 1, 2023	The 2023 report includes recommendation concerning the analysis of rates that occurred in 2022 under the 5-year rate review cycle.
Review of provider rates under the new 3-year rate review schedule goes into effect	during 2024	It is assumed that the first year of the 3-year schedule for rate review will go into effect in 2024 to avoid a year during which no rate review takes place.
Department submits provider rate recommendation report	November 1, 2024	No analysis report is required on May 1, 2024, therefore the only report to be provided to the JBC in 2024 is the recommendation report. This report will be the last report concerning provider rate review under the 5-year cycle and it will be on rates reviewed in 2023
Department submits provider rate review, analysis, and recommendation report	November 1, 2025	This is the first report due to the JBC concerning rates reviewed under the 3-year review schedule and is for rates reviewed in 2024 and addressed in the Department's targeted provider rate adjustment budget request, if such request is submitted, for the FY 2026-27 budget.

FY 2023-24 BUDGET REQUEST

The Department's FY 2023-24 R11 Compliance budget request includes a request for $318,378 total funds, including $95,514 General Fund, and 2.8 FTE to hire additional staff in order to comply with the three-year rate review timeline and stakeholder process requirements of S.B. 22-236. The request annualizes to $331,032 total funds, including $99,310 General Fund, and 3.0 FTE in FY 2024-25. Funding was not appropriated in bill because the effective date for the process of establishing the three-year rate review cycle is identified in the bill as July 1, 2023. This allowed for the funding to be requested and analyzed during the regular budget process. The Department's request will be discussed during the JBC staff figure setting presentation in March 2023.