MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	November 14, 2016
SUBJECT	Medicaid provider rate review schedule

Pursuant to statute[1], the JBC must decide by December 1 each year if it wants to direct the Department of Health Care Policy and Financing to review a Medicaid rate out of the established rate review schedule, or include an exempted rate in the review. This memo provides background information to help the JBC decide if it wants to make any modifications to the rate review schedule. The JBC staff does not recommend any modifications at this time.

The Department must conduct periodic rate reviews pursuant to S.B. 15-228, sponsored by the JBC, to compare Medicaid rates to available benchmarks and to use metrics to assess whether payments are sufficient to: allow provider retention and client access; and, support appropriate reimbursement of high-value services. The rate reviews are intended to inform the Governor's annual budget request and the General Assembly's deliberations. The Department of Health Care Policy and Financing developed the attached schedule so that each rate is reviewed at least once every five years, as required by statute. The Department also identified rates that will be exempted from review because they are adjusted periodically as a result of another state or federal law or regulation. The Department just completed Year 1 of the rate review cycle and submitted a report to the JBC on November 1 that will be discussed during the budget briefing. The Department is about to begin Year 2 of the rate review.

The Medicaid Provider Rate Review Advisory Committee (MPPRAC) also has authority to direct a change to the rate review schedule. According to the Department, the MPPRAC is considering moving the review of ESRD and Dialysis rates, which is a subcategory of physician services that is currently scheduled for review in Year 2, to Year 4 when rates for dialysis centers will be reviewed.

The Department presented to the Medicaid Provider Rate Review Advisory Committee several factors that were considered in developing the rate review schedule. In that presentation, the Department emphasized that if the Advisory Committee or the JBC direct any out-of-cycle reviews, the Department may have to adjust the scheduled review times of other rates to get the work done. Some of the factors the Department considered in developing the schedule include:

- Grouping similar services to facilitate comparison;
- Balancing the Department staff's workload;
- Allowing time in the last year for unexpected changes to the review schedule, either for policy or technical reasons;
- Aligning the rate review schedule with the public release of key benchmarks, such as the American Dental Association Survey of Fees; and
- Synchronizing the rate review schedule with key Department deadlines, like a waiver reauthorization or the rebid of a service contract.

[1] Section 25.5-4-401.5 (1) C.R.S., subparagraphs (b) and (c).

Recommendation: The JBC staff does not recommend any modification to the rate review schedule. The recommendation is to allow the executive branch to proceed in the order deemed most administratively feasible by the Department. The proposed grouping of similar services, the alignment of the schedule with the public release of key benchmarks, and the synchronizing of the schedule with key Department deadlines all appear to be reasonable decisions that will promote better policy debate. The proposed exemptions for rates that are adjusted periodically as a result of another state or federal law or regulation appear appropriate.

Colorado Medicaid Five Year Provider Rate Review Schedule

The Department of Health Care Policy and Financing (Department) oversees and operates Colorado Medicaid, Child Health Plan *Plus* (CHP+), and other public health care programs for the state of Colorado.

CRS 25.5-4-401.5 requires that the Department create a Rate Review Process and determine a schedule that ensures an analysis and reporting of each Medicaid provider rate at least every five years. The process includes an analysis of the access, service, quality, and utilization of each service subject to review. The analysis will compare the rates paid with Medicare rates, usual and customary rates paid by private pay parties and other benchmarks, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high value services.

The statute establishes an Advisory Committee (Committee), appointed by the Legislature, to assist the Department in the Rate Review Process. The Advisory Committee can recommend changes to the five year schedule, review and provide input on submitted reports, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

The Rate Review Process will be completed in four phases:

Phase 1. Develop a five-year schedule of rates to review
Phase 2. Conduct analyses of and rate comparisons for rates under review that year
Phase 3. Develop strategies for responding to the analyses results
Phase 4. Provide annual recommendations on all rates reviewed

The Rate Review Process aligns with proposed regulations issued by Centers for Medicare and Medicaid Services in 2011[1] regarding the creation of a method to monitor access to care as impacted by rate changes, particularly rate reductions.

This submission contains the Department's recommendations for Phase 1 – the development of a five year schedule of rates to review – and includes three sections:

Section A. The Department's Rate Setting Work and Provider Rate Reviews
Section B. Rate Review Schedule
Section C. Proposed Excluded Rates

Section A. The Department's Rate Setting Work and Provider Rate Reviews

Although they are related, it is important to distinguish the difference between the Department's ongoing rate setting work and the new Rate Review Process. These activities are related but require separate activities. The Rate Review Process proposes a schedule to analyze and compare rates for existing providers or services every year. This effort will greatly enhance the Department's ongoing rate setting and rate update work that is required for the effective functioning of the Medicaid program. Some examples of this work include:

- Update and maintenance of provider and health plan rates throughout the year as required by applicable state and federal laws, regulations, and actuarial standards of practice

[1] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (May 2011) - Proposed Rule (CMS-2328-F)

- Updates for existing covered services that require the calculation of new rates when 1) components of a rate change, or 2) when the payment methodology changes (such as the replacement of a brand-name drug with a generic drug)
- The addition, redesignation, or deletion of procedure codes for an existing set of services. In these instances the rates are reviewed, and updated if necessary, while implementing relevant procedure code changes (such as when the current cost-based payment methodology used for outpatient hospital services will be replaced by a prospective payment system beginning in November 2016[2]. In this instance, a new base rate needs to be developed for reimbursement)
- New services and provider types that require development of a payment methodology or rate. Examples of new services offered to Medicaid beneficiaries are genetic testing, new flu vaccines, and new drugs (an example of a new provider type is non-waiver Personal Care Providers)
- Rates that need to be adjusted as a result of budgetary appropriations to the Department

The rate setting work described above focuses on a narrow and specific set of rates or services. By contrast, the Rate Review Process will provide a full analysis of access and utilization for a broader set of rates and services to determine whether Medicaid provider payments are sufficient to allow for provider retention and client access.

Section B. Rate Review Schedule

Development of the five-year rate review schedule required that all services be categorized in a manner that would ensure each rate was reviewed at least once every five years. The Department's MMIS groups Medicaid services by 1) category of service and 2) sub-category of service, for claims adjudication. The Department used these categories and sub-categories to group all procedure codes to facilitate the five year review requirement. The Department then identified which of these should be included or excluded for rate review, and prioritized the included categories of service over a five year period. The resulting proposed schedule for each year is included below.

The first year of review focuses on categories of service for which the programs are clearly defined. Policies for these codes have been static, rates and their methodologies are known, and procedure codes are easily comparable to Medicare and/or other benchmarks. The Department is confident in its ability to conduct a full analysis of the recommended rates within the timeframe specified. Additionally, this strategy will allow for the identification and implementation of process improvements as the Department gains experience with annual rate reviews.

Completing the schedule for the remaining four years involved several elements including:

- The ability to align the rate review with upcoming changes to the categories of service. For example, the Home and Community Based Waiver services were placed in year two of the review to allow for alignment with recommendations for waiver modernization originally tasked to the Long Term Care Advisory Committee[3].
- To the extent possible, selected categories of services were scheduled for review in sequence to the public release of relevant rate benchmarks. For example, the *American Dental Association Survey of*

[2] The 3M™ Enhanced Ambulatory Patient Grouping (EAPG) System

[3] https://www.colorado.gov/pacific/cdphe/advisory-meetings

Fees[4] is published on a three to four year cycle and it is a key benchmarking resource for Dental rates review.

- Categories of service were grouped for alignment of specific procedure codes to ensure the most efficient review. Physician and Surgery services are divided between two years of the rate review as they represent the largest number of codes for review. Each of the surgical procedure code sets was matched with corresponding physician services. Aligning categories of service in this manner ensures all rates in similar categories of service are reviewed in conjunction, allows identification of correlations between categories of services, and provides more robust understanding of the impact of rates across Medicaid.
- Complicated rate methodologies for specific categories of services will require additional resources for the development of an analysis and review. While a rate review of Ambulatory Surgical Centers (ASC) requires a review of only 10 rates, these rates are bundled payments composed of more than 2,000 procedure codes. Categories of service identified as having complicated or multiple rate methodologies were placed in the fourth and fifth years of review to allow the Department time to develop 1) a complete understanding of the rates and rate methodologies, and 2) a process for performing a review of these rates.
- Finally, categories of service for which the Department policy is expected to change or undergo revisions were placed in the final year of the review.

Changes by the Committees to the recommended schedule may need to be offset by moving a corresponding set of proposed rates to another year to ensure the Department's ability to complete the full set of analyses.

The proposed schedule for each year is listed by Service Type and includes the number of service codes and the number of rates. The number of codes may not always equal the number of rates. For instance, in Year One, different codes are used to designate "acute care services" within Home Health from "long-term" Home Health services, although many codes share the same rate.

Year One (December 2015 – May 2016)

Service Type	No. of Codes	No. of Rates
County and Brokered Non-Emergent Transportation	17	17
Emergency Transportation	12	12
Private Duty Nursing	5	5
Home Health	22	10
Pathology and Laboratory	1,515	1,515
Physician Administered Drugs (J Codes)	743	743
Total	**2,314**	**2,302**

[4] The 2013 survey results are located at http://www.ada.org/en/science-research/health-policy-institute/dental-statistics/fees-for-dental-procedures.

Year Two (June 2016 – May 2017)

Service Type	No. of Codes	No. of Rates
Home and Community Based Services Waivers	**204**	**186**
HCBS waiver for Persons with Spinal Cord Injury	32	3
HCBS for Person with Brain Injury	50	22
HCBS Children's Extensive Supports	20	4
HCBS Children's Habilitative Residential Program	9	27
HCBS Children with Autism	5	4
HCBS waiver for Persons with Developmental Disability	13	66
HCBS for Person who are Elderly, Blind Disabled	21	28
HCBS Community Mental Health Supports	16	0
HCBS Children with Life Limiting Illness	9	10
HCBS Supported Living Services waiver	27	20
HCBS Children's waiver	2	2
Anesthesia	**326**	**326**
Surgery	**4,483**	**4,483**
Integumentary Systems	494	494
Musculoskeletal Systems	1,658	1,658
Respiratory Systems	405	405
Cardiovascular System	889	889
Digestive System	1,037	1,037
Physician Services	**495**	**495**
ESRD and Dialysis Treatments	29	29
Gastroenterology	21	21
Ophthalmology	86	86
Ear, Nose, Throat (including Speech)	91	91
Cardiology	175	175
Vascular	27	27
Respiratory	54	54
Cognitive Capabilities Assessments	12	12
Targeted Case Management (DIDD)	1	1
Total	**5,509**	**5,491**

Year Three (June 2017 – May 2018)

Service Type	No. of Codes	No. of Rates
Surgery	**1,320**	**1,320**
Urinary System	331	331
Male/Female Genital System and Maternity	432	432
Endocrine System	37	37
Nervous System	520	520
Physician Services	**1,223**	**1,223**
Evaluation and Management	156	156
Radiology	675	675
Vaccines and Immunizations	110	110
Psychiatric Treatment	35	35
Allergy	36	36
Sleep Studies	5	5
Neurology	87	87
Motion Analysis	2	2
Genetic Counseling	1	1
Health and Behavior Assessments	6	6
Infusions and similar products	40	40
Diagnostic and Therapeutic Skin Procedures	10	10
Physical Therapy	42	42
Treatment of Wounds	8	8
Miscellaneous Services	10	10
Dental Services	**657**	**657**
Total	**3,200**	**3,200**

Year Four (June 2018 – May 2019)

Service Type	No. of Codes	No. of Rates
Ambulatory Surgical Centers	2,649	10
RCCF, TRCCF, PRTF	22	22
Dialysis	1	84
Family Planning Services	44	44
DME	733	988
Total	**3,449**	**1,148**

Year Five (June 2019 – May 2020)

Service Type	No. of Codes	No. of Rates
Prosthetics	888	888
Eyeglasses	79	79
Disposable Supplies	645	645
Total	**1,612**	**1,612**

The Department proposes to maintain capacity in Year Five to accommodate the need to evaluate potential new benefits, changes to the recommended schedule based on off-cycle reviews required by the Committee, newly covered benefits, and reviews required by new statutory and/or regulatory mandates.

Section C. Proposed Excluded Rates

The Department is recommending a number of service categories to be excluded from the Rate Review Process when those rates are based on costs, have a regular process for updates (and that process is delineated in statute or regulation), are under a managed care plan, or are payments unrelated to a specific service rate.

Medicaid payer of last resort:
Medicare crossover claims should be excluded from the rate review process because crossover claims do not reflect a payment for specific services. A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary) member sent to Medicaid for payment of coinsurance, copayment, and deductible.

Incentive Payments:
Similar to crossover payments, incentive payments do not reflect a rate-based payment for services. Incentive payments are contractually-based and calculated based on providers meeting a set of quality indicators that are specific to the contracted group.

Contracted Plans:
Contracted Health Maintenance Organizations (HMO) and Behavioral Health Organizations (BHO)[5] are reimbursed based on an annually-calculated per-member per-month or capitated rate. Capitated rates are reviewed annually by HCPF actuaries, are set in contract, and are updated for each contract renewal period. The contract includes a table of actuarially-computed rates that HCPF will pay.

Selected Regular Rate Setting Work:
Inpatient Hospitals[6]: Inpatient rates are revised annually and are based on updated Medicare base rates with specific Medicaid cost-add-ons. The payment methodology uses Diagnosis Related Groups (DRG) weights that are updated at least every other year.

DRG Grouper: This is a service category that refers to the weights used for inpatient hospital services. The latest update to the weights was completed for the January 1, 2014 All Patient Refined Diagnosis Related Group (APR-DRG) implementation. The calculation of the weights involves analysis of cost, payment, and utilization of the covered inpatient services.

Outpatient Hospital[7]: Except for Transportation, payment for outpatient hospital services is based on costs. A prospective payment methodology – Enhanced Ambulatory Patient Grouping System (EAPG) - is planned for November 2016 to replace the current cost-based payment schema. Similar to inpatient hospital reimbursement, specific cost information will be included in the rate to account for cost variation across

[5] 10 CCR 2505-10 Section 8.205 - 8.215 - Managed Care; CRS 25.5-5-407.5. Prepaid inpatient health plan agreements; 25.5-5-411.Medicaid community mental health services (4)b
[6] 10 CCR 2505-10 Section 8.300.5; CRS 25.25-4-402
[7] 10 CCR 2505-10 Section 8.300.6

providers. Transportation, which will not be affected by the EAPG transition, will remain under the current fee schedule payment methodology and will be reviewed in Year One.

Clinic:

FQHC[8] and **RHC**[9]: Federally Qualified Health Centers and Rural Health Centers are reimbursed prospectively. FQHC and hospital based RHC rates are reviewed and updated annually based on audited cost report information. Free-standing RHC rates are reimbursed based on the maximum federal rate which is updated annually.

School Based Clinic Services[10] and **School Based Clinic Case Management**[11]**:** These services are reimbursed at cost. Rates are based on a per unit reimbursement, reconciled annually through a cost settlement.

Facility:

Nursing Facility[12] **Class I** and **Class V:** Nursing facility rates are cost-based and calculated annually following the submission of cost reports. Nursing facility reimbursement is governed by statute 25.5-600.2 and requires that rates are updated annually and based on costs reported by facilities each July 1.

Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID)[13] **Class II** and **Class IV:** Intermediate Care Facility rates are cost based and calculated annually following the submission of cost reports. ICF/IID reimbursement is governed by statute 25.5-600.2 and requires that rates are updated annually and set based on costs reported by facilities each July 1.

Prescribed Drugs:[14]

Title XIX Drugs: These rates are under continual review. Compliance with federal regulations requires ongoing rate revision due to the continuous fluctuation of prices.

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[8] 10 CCR 2505-10 Section 8.700

[9] 10 CCR 2505-10 Section 8.740

[10] 10 CCR 2505-10 Section 8.290.6 -8.290.8; CRS 25.5-5-318

[11] Ibid

[12] 10 CCR 2505-10 Section 8.443; CRS 25.5-6-201; CRS 25.5-6-202

[13] CRS 25.5-6-204

[14] 10 CCR 2505-10 Section 8.800.13