MEMORANDUM

TO: Members of the Joint Budget Committee
FROM: Robin Smart, JBC Staff (303-866-4955)
DATE: April 28, 2022
SUBJECT: LLS 22-1042 Concerning the review of Medicaid provider rates.

LLS 22-1042 (Review of Medicaid Provider Rates) makes the following changes to section 25.5-4-401.5, C.R.S.:

- Beginning August 1, 2023, changes the provider rate review cycle from every 5 years to every 3 years;
- Beginning August 1, 2023, requires the Department of Health Care Policy and Financing (HCPF) to provide written notification to the Joint Budget Committee and the advisory committee of any reasons why it is unable to perform a requested out of cycle rate review;
- Requires HCPF to utilize information concerning the prior authorization processes and billing structure for provider rates if the information is relevant to the review in order to minimize rate disparities;
- Requires HCPF to host quarterly public meetings to inform the review process;
- Changes the reporting requirements for HCPF from two annual reports to one annual report due to the Joint Budget Committee by November 1 of each year;
- Changes the structure of the advisory committee from 24 members to 7 members and requires members to have proven expertise related to Medicaid in one or more specified areas; and
- Requires the Medicaid Provider Rate Review Committee to present annually by December 1, an overview of the rate review process, a summary of the provider rates that were reviewed, and the strategies for responding to the findings of the rate review.

The bill contains an effective date clause of August 1, 2023 which allows for existing statute to remain in effect until the effective date of the bill. As a result the required May 1, 2022 and May 1, 2023 analysis reports and the November 1, 2022 recommendation report must still be submitted. The November 1, 2023 report is required to contain both the information provided in the May 1, 2023 analysis report and the additional information required pursuant to section (2)(d)(I) of the bill, except that quarterly stakeholder meetings are required to commence upon enactment of the bill and therefore that information will not be available.

The Department has expressed concern related to the following provisions of the bill draft:

- Page 2, line 6 – the Department has expressed concern related to the delivery of the 3-year cycle rate review schedule on or before September 1, 2023 and indicated that more discussion is necessary concerning the transition period from one process to the next. The Department interprets the language in the bill to indicate that the 2022 and 2023 analysis and recommendation reports would be eliminated.
  - While it would have been helpful if the Department had suggested a timeline for activities identified in this bill, that input was not provided.
  - As indicated above, the effective date ensures that the 2022 and 2023 reports are not eliminated.
  - The first report of the new cycle may need be changed to November 1, 2024.
Page 3, line 13 – the Department would prefer that the language read “by December 1 two years prior to the due date of the report required pursuant to section (2)(b) in which the out of cycle review will be included. Proportionate additional funding must be appropriated to the Department.”
  o JBC staff recommends maintaining the existing language. If the Committee elects to consider the Department’s suggested language, staff strongly recommends that the language concerning additional appropriations be excluded from the bill. Additional funding should be requested during the regular budget process.

Page 4, lines 18 through 23 – the Department requests that this language be struck from the bill.
  o JBC staff believes that prior authorization policy and the billing structure for services impacts access to care and available services, primarily when there are competitive provider agency types who provide the same services but under different requirements.

Page 5, lines 1 through 22 – the Department suggest striking this material and substituting language making analysis topics permissive as opposed to prescriptive.
  o JBC staff recommends maintaining the existing language.

JBC staff believes that the only necessary changes to the draft include:
  • A correction in the third paragraph of the summary to accurately reflect the language in the bill draft; and
  • A correction in the due date for the first report of the new 3-year review cycle from November 1, 2023 to November 1, 2024.

If the Committee determines that the bill draft is not ready for introduction, JBC staff recommends that additional discussion take place during the interim and that a bill draft be considered during the next legislative session.

An alternative to not sponsoring the legislation would be to strike pages 2 through 4 and strike lines 1 through 19 of page 6. The bill would then change the structure of the advisory committee and require the advisory committee to present annually to the Joint Budget Committee.
Joint Budget Committee

BILL TOPIC: "Review Of Medicaid Provider Rates"
DEADLINES: File by: 4/28/2022

A BILL FOR AN ACT
CONCERNING THE REVIEW OF MEDICAID PROVIDER RATES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov/.)

Joint Budget Committee. Current law requires the department of health care policy and financing (state department) to establish a schedule for a review of provider rates paid under medicaid so that each provider rate is reviewed at least every 5 years and to provide the schedule to the joint budget committee (JBC). Beginning August 1, 2023, the bill requires the state department to establish a schedule so that each provider rate is reviewed at least every 3 years and to provide the schedule to the medicaid provider rate review advisory committee (advisory committee)
in addition to the JBC.

Current law authorizes the advisory committee or the JBC, by a majority vote, to direct the state department to conduct a review of a provider rate that is not scheduled for review during that year. Effective August 1, 2023, if the state department determines the request for an out-of-cycle review cannot be conducted, the bill requires the state department to provide written notification to the advisory committee and the JBC within 30 days after the request is made stating the reasons the out-of-cycle request cannot be conducted.

Effective August 1, 2023, the bill requires the state department to review the prior authorization process and billing structure for provider rates that are reviewed and to determine if changes are needed.

Effective August 1, 2023, the bill requires the state department to conduct a public meeting at least quarterly to inform the state department's review of provider rates.

Current law requires the advisory committee consist of 24 members. Effective August 1, 2023, the bill decreases the advisory committee to 7 members and requires the members to have proven expertise related to medicaid in one or more specific areas. The advisory committee is currently scheduled to sunset September 1, 2025. The bill moves the sunset to September 1, 2036.

On or before December 1, 2024, and each December 1 thereafter, the bill requires the advisory committee to 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.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, amend with relocated provisions 25.5-4-401.5 as follows:

25.5-4-401.5. Review of provider rates - advisory committee - recommendations - repeal. (1) (a) On or before September 1, 2023, the state department shall establish a schedule for an annual review of provider rates paid under the "Colorado Medical Assistance Act" so that each provider rate is reviewed at least every five years and shall provide the schedule to the ADVISORY COMMITTEE ESTABLISHED PURSUANT TO SUBSECTION (3) OF THIS SECTION AND THE joint budget
committee. If the state department receives any petitions or proposals for provider rates to be reviewed or adjusted, the state department must forward a copy of the petition or proposal to the advisory committee AND THE JOINT BUDGET COMMITTEE.

(b) The state department shall review each of the provider rates scheduled for review pursuant to the process described in this section. Additionally, The advisory committee established pursuant to subsection (3) of this section, by a majority vote, or the joint budget committee MAY, by a majority vote, may direct that the state department conduct a review of a provider rate that is not scheduled for review during that year. The advisory committee or the joint budget committee shall notify the state department OF THE REQUEST FOR AN OUT-OF-CYCLE REVIEW by December 1 of the year prior to the year in which the out-of-cycle review will take place. IF THE STATE DEPARTMENT DETERMINES THAT THE REQUEST FOR AN OUT-OF-CYCLE REVIEW CANNOT BE CONDUCTED, THE STATE DEPARTMENT SHALL PROVIDE WRITTEN NOTIFICATION TO THE ADVISORY COMMITTEE AND THE JOINT BUDGET COMMITTEE WITHIN THIRTY DAYS AFTER THE REQUEST FOR AN OUT-OF-CYCLE REVIEW. THE NOTIFICATION MUST INCLUDE A DESCRIPTION OF THE REASONS THE OUT-OF-CYCLE REVIEW CANNOT BE CONDUCTED.

(c) (I) The state department may propose to exclude rates from the schedule established pursuant to paragraph (a) of this subsection (1) SUBSECTION (1)(a) OF THIS SECTION if those rates are adjusted on a periodic basis as a result of other state statute or federal law or regulation. The state department shall include the proposed list of exclusions with the schedule established pursuant to paragraph (a) of this subsection (1) SUBSECTION (1)(a) OF THIS SECTION.
(II) The advisory committee or the joint budget committee may, by a majority vote, direct the state department to include any rate that the state department has proposed to exclude from the schedule.

(2) (a) In the first phase of the review process, the state department shall:

(I) Conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. The state department shall compare the rates paid with available benchmarks, including medicare rates and usual and customary rates paid by private pay parties, 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. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before May 1, 2016, and each May 1 thereafter, the state department shall provide a report on the analysis required by this paragraph (a) to the advisory committee, the joint budget committee, and any stakeholder groups identified by the state department whose rates are reviewed.

(II) Utilize information made available by the state department concerning the prior authorization process and billing structure for provider rates if such information is relevant to the review performed pursuant to subsection (1)(a) of this section in order to minimize rate disparities for services in professional classifications that are eligible for reimbursement under the medical assistance program.

(b) Following the report analysis required by paragraph (a) of this subsection (2) of this section, the state department shall work with the advisory committee and any stakeholders
identified by the state department or the advisory committee to review the report analysis and develop strategies for responding to the findings, including any nonfiscal approaches or rebalancing of rates and strategies to address capacity issues that may exist in certain regions of the state.

(c) Following the review required by paragraph (b) of this subsection (2) of this section, the state department shall work with the office of state planning and budgeting to determine achievable goals and executive branch priorities within the statewide budget.

(d) (I) Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2016 2023, and each November 1 thereafter, the state department shall submit a written report to the joint budget committee and the advisory committee containing its analysis required pursuant to subsection (2)(a) of this section, a description of the information discussed during the quarterly public meeting conducted pursuant to subsection (2)(e) of this section, and the state department's recommendations on all of the provider rates reviewed pursuant to this section and all of the data relied upon by the state department in making its recommendations. The joint budget committee shall consider the recommendations in formulating the state department's budget for the state department.

(II) The state department shall submit, as part of the report required pursuant to this subsection (2)(d), a description of the information discussed during the quarterly public meeting; the state department's response to the public comments received from providers, recipients, and other interested
PARTIES; AND AN EXPLANATION OF HOW THE PUBLIC COMMENTS INFORMED
THE PROVIDER RATE REVIEW PROCESS AND THE RECOMMENDATIONS
CONCERNING RATES AND PRIOR AUTHORIZATION REQUIREMENTS.

(e) The state department shall conduct a public meeting
at least quarterly to inform the state department's review of
provider rates paid under the "COLORADO MEDICAL ASSISTANCE
ACT". The state department shall invite to the public meeting
providers, recipients, and other interested parties directly
affected by the services scheduled to be reviewed at the public
meeting. At a minimum, each public meeting must consist of, but
is not limited to:

(I) A discussion of the analysis and review performed
pursuant to subsection (2)(a) of this section; and

(II) Public comments from providers, recipients, and other
interested parties concerning:

(A) The analysis and review performed pursuant to
subsection (2)(a) of this section; and

(B) Recommended changes to the provider rate review
process that may enhance or improve the process.

(3) (a) There is created in the state department the medicaid
provider rate review advisory committee, referred to in this section as the
"advisory committee", to assist the state department in the review of the
provider rate reimbursements under the "COLORADO MEDICAL ASSISTANCE
Act". The advisory committee shall:

(I) Review the schedule for annual review of provider rates
established by the state department pursuant to paragraph (a) of
subsection (1) subsection (1)(a) of this section and recommend any
changes to the schedule;

(II) Review the ANALYSIS PERFORMED PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION AND THE reports prepared by the state department on its analysis of provider rates pursuant to paragraph (a) of subsection (2) SUBSECTION (2)(d) of this section and provide comments and feedback to the state department AND THE JOINT BUDGET COMMITTEE on the reports;

(III) With the state department, conduct public meetings to allow providers, recipients, and other interested parties an opportunity to comment on the report required by paragraph (a) of subsection (2) REVIEW THE COMMENTS RECEIVED FROM PROVIDERS, RECIPIENTS, AND OTHER INTERESTED PARTIES AND THE STATE DEPARTMENT'S RESPONSE TO THE COMMENTS REQUIRED PURSUANT TO SUBSECTION (2)(d)(II) of this section;

(IV) Review proposals or petitions RECEIVED BY THE ADVISORY COMMITTEE for provider rates to be reviewed or adjusted; received by the advisory committee;

(V) Determine whether any provider rates not scheduled for review during the next calendar year should be reviewed during that calendar year;

(VI) Recommend to the state department and to the joint budget committee any changes to the process of reviewing provider rates, including measures to increase access to the process, such as by providing for electronic comments by providers and the public; and

(VII) Provide other assistance to the state department AND THE JOINT BUDGET COMMITTEE as requested by the state department or the joint budget committee.

(b) (I) The advisory committee consists of the following
twenty-four seven members:

(A) Three members appointed by the governor;

(B) Two members appointed by the President of the Senate,
or the President's designee; and

(C) Two members appointed by the Speaker of the House of
representatives, or the Speaker's designee.

(II) Each member appointed to the advisory committee
must have proven expertise related to the medical assistance
program in one or more of the following areas:

(A) Service delivery or case management services
provided to one or more eligible populations;

(B) Provider finance or budget;

(C) Service capacity analysis;

(D) Business processes;

(E) Claims filing or processing; or

(F) Implementation of state and federal Medicaid rules,
regulations, and guidance.

(III) The state department may make recommendations to
the Governor, the President of the Senate, and the Speaker of the
House of representatives concerning the qualifications of
members appointed to the advisory committee.

(I) The following members appointed by the President of the
Senate:

(A) A recipient with a disability or a representative of recipients
with a disability;

(B) A representative of hospitals providing services to recipients
recommended by a statewide association of hospitals;
(E) A representative of providers of transportation;
(D) A representative of rural health centers;
(E) A representative of home health providers recommended by a statewide organization of home health providers; and
(F) A representative of providers of durable medical equipment recommended by a statewide association of durable medical equipment providers;

(II) The following members appointed by the minority leader of the senate:
(A) A representative of providers of behavioral health-care services;
(B) A representative of primary care physicians who see recipients recommended by a statewide association of primary care physicians;
(C) A representative of dentists providing services to recipients recommended by a statewide association of dentists;
(D) A representative of federally qualified health centers;
(E) A representative of nonmedical home- and community-based service providers; and
(F) A representative of providers serving recipients with intellectual and developmental disabilities;

(III) The following members appointed by the speaker of the house of representatives:
(A) A representative of child recipients with a disability;
(B) A representative of specialty care physicians not employed by a hospital who see recipients recommended by a statewide association whose members include at least one-third of the doctors of medicine or osteopathy licensed by the state;
(C) A representative of providers of alternative care facilities recommended by a statewide association of alternative care facilities;

(D) [Editor's note: This version of subsection (3)(b)(III)(D) is effective until July 1, 2024.] A representative of single entry point agencies;

(D) [Editor's note: This version of subsection (3)(b)(III)(D) is effective July 1, 2024.] A representative of case management agencies;

(E) A representative of ambulatory surgical centers;

(F) A representative of hospice providers recommended by a statewide association of hospice and palliative care providers; and

(IV) The following members appointed by the minority leader of the house of representatives:

(A) A representative of substance use disorder providers recommended by a statewide association of substance use disorder providers;

(B) A representative of facility-based physicians who see recipients. For purposes of this sub-subparagraph (B), "facility-based physicians" include anesthesiologists, emergency room physicians, neonatologists, pathologists, and radiologists:

(C) A representative of pharmacists providing services to recipients;

(D) A representative of managed care health plans;

(E) A representative of advanced practice nurses recommended by a statewide association of nurses; and

(F) A representative of physical therapists or occupational therapists recommended by a statewide association representing occupational or physical therapists:
(c) The appointing authorities shall make their initial appointments to the advisory committee no later than August 1, 2015. In making appointments to the advisory committee, the appointing authorities shall make a concerted effort to include members of diverse political, racial, cultural, income, and ability groups and members from urban and rural areas.

(d) Each member of the advisory committee serves at the pleasure of the official who appointed the member. Each member of the advisory committee serves a four-year term and may be reappointed.

(e) The members of the advisory committee serve without compensation and without reimbursement for expenses.

(f) At the first meeting of the advisory committee, to be held on or after September 1, 2023, the members shall elect a chair and vice-chair from among the members.

(g) The advisory committee shall meet at least once every quarter. The chair may call such additional meetings as may be necessary for the advisory committee to complete its duties.

(h) The advisory committee shall develop bylaws and procedures to govern its operations.

(i) On or before December 1, 2023, and each December 1 thereafter, the advisory committee shall present to the Joint Budget Committee 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, including any fiscal or nonfiscal approaches or rebalancing of rates, any advisory committee recommendations for rate adjustments made to the state department, and any
RECOMMENDATIONS FOR IMPROVING CAPACITY AND ACCESS TO SERVICES IN REGIONS OF THE STATE WHERE REDUCED CAPACITY RESULTS IN LIMITED ACCESS TO SERVICES.

(i) (j) (I) This subsection (3) is repealed, effective September 1, 2025/2034.

(II) Prior to repeal, the department of regulatory agencies shall conduct a sunset review of the advisory committee pursuant to the provisions of section 2-3-1203. C.R.S.

SECTION 2. In Colorado Revised Statutes, 2-3-1203, repeal (16)(a)(I); and add (23) as follows:

2-3-1203. Sunset review of advisory committees - legislative declaration - definition - repeal. (16) (a) The following statutory authorizations for the designated advisory committees will repeal on September 1, 2025:

(I) The medicaid provider rate review advisory committee created in section 25.5-4-401.5, C.R.S.;

(23) (a) THE FOLLOWING STATUTORY AUTHORIZATIONS FOR THE DESIGNATED ADVISORY COMMITTEES WILL REPEAL ON SEPTEMBER 1, 2034:

(I) THE MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE CREATED IN SECTION 25.5-4-401.5;

(b) THIS SUBSECTION (23) IS REPEALED, EFFECTIVE SEPTEMBER 1, 2036.

SECTION 3. Act subject to petition - effective date. This act takes effect August 1, 2023; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period
after final adjournment of the general assembly, then the act will not take
effect unless approved by the people at the general election to be held in
November 2022 and, in such case, will take effect August 1, 2023, or on
the date of the official declaration of the vote thereon by the governor,
whichever is later.