MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	March 20, 2017
SUBJECT	Community Provider Rates Additional Information

Representative Hamner asked for several pieces of additional information regarding community provider rates.

1 What provider rate adjustments has the JBC already approved for the FY 2017-18 budget?

The table below summarizes provider rate adjustments approved by the JBC and a couple items that were tabled or rejected by the JBC that might be readdressed during comebacks. The table focuses on rates that are changing as a result of a discretionary policy of the JBC and not on changes due to a statutory formula or federal regulation. Examples of some of the larger rate changes excluded from the table are nursing home rates that increase 3 percent by statute, capitated rates for managed care entities that must be actuarially sound, rates for Federally Qualified Health Centers that are adjusted annually by federal regulation, pharmacy rates that are based on acquisition cost, and provider fee booster payments that adjust by statutory formula absent a restriction on revenue.

Community Provider Rate Increases Approved by the JBC				
	FY 17-18		FY 18-19	
	Total Funds	General Fund	Total Funds	General Fund
Human Services				
County Administration (SNAP and other programs)	$16,666,666	$5,000,000	$16,666,666	$5,000,000
Health Care Policy and Financing				
R6 Delivery System and Payment Reform				
Primary Care	$54,085,240	$18,846,157	$60,413,683	$21,051,321
Behavioral Health	$0	$0	$26,717,069	$7,215,319
Payments to Regional Accountable Entities	$0	$0	$16,271,367	$6,315,635
R7 Oversight of State Resources				
Office Administered Drugs	$39,320	$11,586	$2,164,801	$637,679
R16 CU School of Medicine booster payment				
Net benefit to CU School of Medicine	$61,521,432	$0	$61,337,568	$0
Public Health and Environment				
Local Public Health Agency Partnerships	$355,500	$0	$355,500	$0
TOTAL	**$132,668,158**	**$23,857,743**	**$183,926,654**	**$40,219,954**

Community Provider Rate Increases Approved by the JBC				
	FY 17-18		FY 18-19	
	Total Funds	General Fund	Total Funds	General Fund
Items Not Approved by the JBC				
Corrections				
Community Corrections Facility Payment	$821,345	$821,345	$821,345	$821,345
Health Care Policy and Financing				
Restrict Hospital Provider Fee				
Net benefit to Hospitals	($195,000,000)	($195,000,000)	$0	$0

2 **What were the recommendations from the Medicaid Provider Rate Review Advisory Committee?**

In this cycle the Department reviewed rates for 2,314 medical procedure codes, out of approximately 13,770 codes that will eventually be reviewed through S.B. 15-228. The rates reviewed this year fall into six broad categories:

- Laboratory and pathology services
- Home health services
- Private duty nursing
- Non-emergent medical transportation
- Emergency medical transportation
- Physician-administered drugs

The Department recommended a change to physician-administered drugs that the JBC approved. The Department did not recommend changes for any of the other rates reviewed in this cycle, but the Medicaid Provider Rate Review Advisory Committee had concerns about some of the rates the Department did not recommend changing. The MPRRAC's concerns were primarily focused on home health services and medical transportation (both non-emergent and emergency). Below is a summary of all of the findings.

RATES REVIEWED IN THIS CYCLE

LABORATORY AND PATHOLOGY SERVICES

Laboratory and pathology providers analyze bodily fluids and specimens to assist in the screening and treatment of diseases and disorders. Where Medicaid rates could be compared to Medicare, the Department estimates that Medicaid paid 88.0 percent of what Medicare paid. This resulted in a difference in payment of roughly $12.9 million total funds, including $3.5 million General Fund.

The Department's recommendation report describes a general impression of the MPRRAC that laboratory service rates may be too high. The report mentions a study by the federal Office of the

Inspector General that concluded Medicare rates may be higher than rates paid by other insurers, and a new federal rule requiring laboratories to report rates from other payers and base Medicare rates on other payers' average rates.

The Department concluded that current rates for laboratory and pathology services are sufficient to provide for provider retention and client access and the Department does not recommend any changes in rates at this time. The Department will reevaluate Medicaid rates after Medicare rates are updated in November 2017 based on the new federal rule.

HOME HEALTH SERVICES

Home health services pay for periodic or intermittent nursing care and for physical, occupational and speech therapy. Services may be provided during recovery from an acute condition or episode, such as post-surgical care, or on a long-term basis with prior authorization review for clients that need services beyond 60 days. The Department believes Medicaid's coverage of home health services is sufficiently different from private insurance or Medicare that the best available benchmark is other states. The Department compared Colorado's rates to six states with recent and readily available data and then expressed Colorado's rates as a percentage of the comparison state's, for rates where a comparison could be made:

- Nebraska 72.5%
- Illinois 108.6%
- North Carolina 109.8%
- Idaho 114.5%
- Ohio 154.4%
- Louisiana 197.1%

If Colorado had reimbursed at Nebraska's rates in FY 2014-15, the Department estimates it would have cost an additional $95.7 million, including $45.3 million General Fund. Conversely, if Colorado lowered reimbursement to Louisiana's rates, it would have saved $124.2 million total funds, including $58.8 million General Fund.

According to the Department's recommendation report, the general impression of the MPRRAC is that home health rates are below market and that the Department should index rates to 90 percent of Medicare's Low-Utilization Payment Adjustment (LUPA) rate. The MPPRAC recommended spreading increases over three years to achieve 90 percent of the LUPA rate. Finally, the MPRRAC recommended investigating a time-based payment method rather than a visit-based payment method. Testimony during MPRRAC meetings identified issues with recruiting and retaining staff and competition with hospitals that offer better wages and benefit packages. The testimony also identified differences in transportation costs and quality of care as issues that may not be appropriately addressed by visit-based reimbursements.

The Department disagreed with the MPPRAC's general impression about the adequacy of rates, concluding that current rates for home health services are sufficient to provide for provider retention and client access, and recommending no changes in rates at this time. The Department noted that providers accommodated an increase in utilization from FY 2013-14 through FY 2014-15, arguing this would not have happened if reimbursement was insufficient.

The Department does not believe Medicare's LUPA rate is an appropriate index for Medicaid. Medicare pays the LUPA rate for clients confined to the home to receive care, which is a higher acuity standard than home health services covered by Medicaid. The Department notes that 57 percent of Medicaid utilizers of home health services were also eligible for Medicare, but received coverage through Medicaid because they did not meet the criteria for Medicare coverage of home health services. Medicare's LUPA rate applies only to elderly populations while Medicaid covers a broader population that includes children and adults and thus a different range of health needs. For example, the most common principle diagnosis for Medicaid long-term home health coverage in FY 2014-15 was infantile cerebral palsy, which is a condition not covered by Medicare. Finally, Medicaid has tiered payments based on visit type that are not comparable to Medicare's LUPA reimbursement structure.

In response to the issues home health agencies reported with hiring and retaining staff, the Department noted that there is evidence of a statewide nursing shortage and raised doubts that a Medicaid-specific rate increase for home health would provide relief. Regarding competition with hospitals for employees, the Department noted there are differences beyond wages in the types of services provided, employee travel requirements, and work schedules. Also, the Department noted that it does not control, and would have difficulty measuring, whether an increase in rates translated to an increase in wages.

The Department provided the following estimate of the additional costs to increase Medicaid home health rates to 90 percent of the Medicare LUPA rates over three years, as suggested by the MPRRAC.

Home Health Rates to 90% of Medicare LUPA				
	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2017-18	$26,691,430	$12,785,520	$185,070	$13,720,840
FY 2018-19	$64,605,748	$30,947,214	$465,483	$33,193,051
FY 2019-20	$113,751,807	$54,488,983	$850,920	$58,411,904

PRIVATE DUTY NURSING

Private duty nursing pays for skilled nursing for clients dependent on medical technology who need more care than is available through home health services. Private duty nursing is an optional benefit of the Medicaid program and not a standard covered service for Medicare or private insurance, so the Department believes the best benchmark comparison is other state Medicaid programs. The Department selected six states with publicly available and recently published data and then expressed Colorado's rates as a percentage of the comparison state's, for rates where a comparison could be made:

- North Carolina 111.8%
- Nebraska 112.4%
- Ohio 125.7%
- Louisiana 135.5%
- Illinois 141.8%
- Idaho 144.7%

The Department's recommendation report indicates that the MPRRAC had similar concerns about provider difficulties recruiting and retaining staff and competition with hospitals as were expressed for the home health services benefit. Some members of the MPRRAC suggested that if rates for Licensed Practical Nurse (LPN) services were increased the use of more expensive Registered Nurse (RN) services might decrease. The MPRRAC recommended the Department gather more information about LPN reimbursement rates from hospitals and long-term acute care facilities to evaluate appropriate funding, and maintain adequate RN reimbursement rates over time.

The Department does not recommend a change in rates, concluding that current rates are sufficient to provide for provider retention and client access. In response to the recommendation from the MPRRAC the Department will survey hospitals and long-term acute care facilities and investigate if other states that have increased LPN rates have experienced a substitution of LPN services for RN services. The Department also plans to collect more information about differences in client populations, facility costs, and types of services provided in facility settings versus home settings to determine if the comparison of LPN wages for facility and home settings is appropriate.

NON-EMERGENT MEDICAL TRANSPORTATION

Non-emergent medical transportation pays to move clients to and from medically necessary services for clients with no other means of transportation. The majority of utilizers and people with disabilities. The Department estimates Colorado's reimbursement rates are 28.2 percent of a rate comparison benchmark based on Medicaid fee schedules from Alabama, Alaska, Arkansas, California, Connecticut, Montana, Nebraska, New Mexico, North Dakota, and Wisconsin.

The Department's recommendation report describes a general impression of the MPRRAC that rates for non-emergent medial transportation are significantly below surrounding state rates. The MPRRAC recommended that the Department collect data on surrounding state rates and strive for parity.

Inconsistent and incomplete data from providers made it impossible for the Department to draw a conclusion on whether rates are sufficient to allow for provider retention and access. Therefore, the Department is not recommending any changes to rates at this time. The Department is working outside the rate process to reduce fragmentation in the administration of the non-emergent medical transportation benefit and improve the consistency and completeness of utilization data. The Department is cooperating with the Public Utilities Commission to implement H.B. 16-1097, which makes permitting for Medicaid providers easier to obtain. Also, the Department reports that it is continuing to implement reforms outlined in the response to FY 2015-16 legislative request for information #5.

EMERGENCY MEDICAL TRANSPORTATION

Emergency Medical Transportation (EMT) pays for emergency ground and air transportation to and from a hospital. The Department estimates Colorado Medicaid reimbursements are 30.7 percent of the benchmark based on Medicare's ambulance fee schedule and Medicaid fee schedules for Alabama, Alaska, Arkansas, California, Connecticut, Montana, Nebraska, New Mexico, North Dakota, and Wisconsin. The Department estimates that bringing EMT and non-emergent medical transportation rates combined to 100 percent of the benchmark would cost $74.1 million total funds, including $25.2 million General Fund.

The MPRRAC emphasized that EMT services must be available around-the-clock, and that EMT services are only reimbursed if a patient is taken to a hospital. The later may provide an incentive for EMT providers to transport patients when it is not warranted. The MPRRAC also discussed challenges providers face with recruiting, training, and retaining staff and a need to analyze ground and air transportation separately in future studies. The MPRRAC recommends initially surveying surrounding state rates and increasing Colorado Medicaid rates to achieve parity. Over time, the MPRRAC recommends moving to parity with Medicare rates. The MPRRAC also recommended that the Department investigate reimbursing for "treat and release" and "supplies used" codes, and reimbursing for alternative transportation vehicles.

The Department concluded that EMT rates are sufficient to allow for client access and provider retention because providers cannot refuse service to clients, but noted that despite access sufficiency the rates may not reflect appropriate reimbursement for high-value services. The Department does not recommend a change in rates at this time, but in response to the MPRRAC recommendations will:

- Gather information on surrounding state rates
- Investigate supplemental funding (similar to the Hospital Provider Fee or Nursing Provider Fee) for EMT services
- Calculate the fiscal impact of opening "treat and release" codes
- Investigate if changes to regulations could lesson potentially-avoidable utilization of EMT services
- Gather more information from EMT providers on the rate components they consider inadequate
- Forecast budgetary impacts of a rate increase for existing EMT services.

PHYSICIAN-ADMINISTERED DRUGS

Physician-administered drugs covers medications and devices that must be delivered in an office under medical supervision. The Department estimates that in aggregate rates are 100.7 percent of the benchmark, but significant variation exists on a drug by drug basis.

The MPRRAC heard testimony that recommended moving long-acting, anti-psychotic injectables from the physician services benefit to the pharmacy benefit to allow for more frequent price updating. The recommendation report describes a general impression of the MPRRAC that current rates are not adjusted frequently enough to keep pace with changes in drug prices both up and down. The MPRRAC recommended indexing rates to the average sales price of the drugs and measures to update pricing more frequently.

The Department concluded that current rates are sufficient to allow for provider retention and client access, but recommends a change to address the inconsistencies on a drug by drug basis identified by the MPPRAC. This is the only component of this year's rate analysis that resulted in a recommended change to the budget. The recommendation is contained in *R7 Oversight of state resources*.

The Department proposes indexing physician-administered drugs to an average of 2.5 percent above the average sales price for the drugs and updating rates periodically to provide an incentive for more providers to administer the drugs. The Department believes this will result in some cost avoidance by reducing trips to hospitals to receive the drugs, where the billing to Medicaid would be higher. Also, it may result in patients accessing drugs that are more effective for them, such as an injected anti-psychotic that lasts thirty days instead of a daily oral pill. That 2.5 percent premium above the average sales price is intended to encourage more providers to offer this high-value service. The Department requests flexibility to pay more for some

especially useful drugs and balance that with lower payments for other drugs to maintain a 2.5 percent average premium above average sales price.

The Department estimates that implementing the proposed change to physician-administered drug pricing would require an FTE to develop the rates and track the avoided costs. The table below summarizes the projected costs and savings associated with this component of R7.

Physician-Administered Drugs in R7					
	Total Fund	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FTE Costs	$66,796	$33,400	$0	$33,396	1.0
FTE Operating Costs	950	475	0	475	0.0
Cost Avoidance	(1,205,488)	(355,098)	(49,057)	(801,333)	0.0
Rate Impact	2,164,801	637,679	88,097	1,439,025	0.0
TOTAL	**$1,027,059**	**$316,456**	**$39,040**	**$671,563**	**1.0**

3 How have provider rates changed over time and how does this compare to changes in state salaries?

The tables on the next pages provide a history of community provider rates compared to changes in state salaries and a detailed history of provider rates for Medicaid.

HISTORY OF THE COMMUNITY PROVIDER RATE INCREASE

Through FY 1997-98, the JBC provided community providers with cost of living increases based on statewide salary survey increases for personal services and state inflationary increases for operating expenses. This often led to increases of over five percent per year, since community provider personal services constitute over 60 percent of most community providers' budgets and often more than this. This approach was also cumbersome and difficult to apply accurately. Based on a staff recommendation for FY 1998-99, the Committee moved to a standard percentage increase for community providers applied to the entire community provider base. The first year the rate was applied, community providers received an increase at approximately the projected rate of inflation (although actual inflation was ultimately lower). Since that time, rate increases have typically fallen below the actual rate of inflation in the prior calendar year, although there have been some exceptions.

Year	Community Provider Increase/Decrease		State Department Increase/Decrease (base building)*		Denver-Boulder CPI prior calendar year
FY 94-95	Personal Services Food inflation Medical inflation	4.5% 1.8 % 3.3 %	Personal Services Food inflation Medical inflation	4.5% 3.6% 10.2%	CY 93 4.2%
FY 95-96	Personal Services Food inflation Medical inflation	6.0% 4.2% 4.8%	Personal Services Food inflation Medical inflation	4.0% 4.2% 9.6%	CY 94 4.4%
FY 96-97	Personal Services Food inflation Medical inflation Other operating	5.0% 2.2% 4.2% (1.0%)	Personal Services Food inflation Medical inflation Other operating	4.3% 1.0% 4.2% (1.0%)	CY 95 4.3%
FY 97-98	Personal Services Food inflation Medical inflation	5.0% 1.7% 3.7%	Personal Services Food inflation Medical inflation	3.9% 1.7% 3.7%	CY 96 3.5%
FY 98-99	Total base increase	3.0%	Personal Services Food inflation Medical inflation	6.2% 1.6% 3.3%	CY 97 3.3%
FY 99-00	Total base increase	2.0%	Personal Services Food inflation Medical inflation Other operating	5.6% 2.1% 3.2% (1.0%)	CY 98 2.4%
FY 00-01	Total base increase	2.0%	Personal Services Food inflation Medical inflation	6.0% 0.0% 0.0%	CY 99 2.9%
FY 01-02	Total base increase	2.5%	Personal Services Food inflation Medical inflation	7.4% 2.8% 5.8%	CY 00 4.0%
FY 02-03	Total base increase	0.0%	Personal Services Food inflation Medical inflation	6.2% 0.0% 0.0%	CY 01 4.7%
FY 03-04	Total base increase	0.0%	Personal Services Food inflation Medical inflation	0.0% 0.0% 0.0%	CY 02 1.9%

Year	Community Provider Increase/Decrease	State Department Increase/Decrease (base building)*	Denver-Boulder CPI prior calendar year
FY 04-05	Total base increase 0.0%	Personal Services 3.3% Food inflation 0.0% Medical inflation 0.0%	CY 03 1.1%
FY 05-06	Total base increase 2.0%	Personal Services 3.0% Food inflation 2.9% Medical inflation 2.5%	CY 04 0.1%
FY 06-07	Total base increase 3.25%	Personal Services 2.6% Food inflation 2.1% Medical inflation 2.0%	CY 05 2.1%
FY 07-08	Total base increase 1.5%	Personal Services 4.75% Food inflation 1.8% Medical inflation 2.0%	CY 06 3.6%
FY 08-09	Total base increase 1.5%	Personal Services 4.28% Food inflation 0.0% Medical inflation 0.0%	CY 07 2.2%
FY 2009-10	Total base decrease Various	Personal Services** 0.0% Food inflation 0.0% Medical inflation 0.0%	CY 08 3.9%
FY 2010-11	Total base decrease Various	Personal Services** 0.0% Food inflation 0.0% Medical inflation 0.0%	CY 09 (0.6%)
FY 2011-12	Total base change 0.0%	Personal Services** 0.0% Food inflation 0.0% Medical inflation 0.0%	CY 10 1.9%
FY 2012-13	Total base change 0.0%	Personal Services** 0.0% Food inflation 0.0% Medical inflation 0.0%	CY 11 3.7%
FY 2013-14	Total base change 2.0%	Personal Services 3.5% Food inflation 0.0% Medical inflation 0.0%	CY 12 1.9%
FY 2014-15	Total base change 2.5% 2.0% for HCPF providers plus targeted rate increases	Personal Services 3.5% Food inflation 0.0% Medical inflation 0.0%	CY 13 2.8%
FY 2015-16	Total base change 1.7% 0.5% for providers paid from Medical Services Premiums plus targeted rate increases	Personal Services 2.0% Food inflation 0.0% Medical inflation 0.0%	CY 14 2.8%
FY 2016-17	Total base change 0.0% Primary care providers and hospitals saw a reduction due to the sunset of the primary care rate bump and a restriction on Hospital Provider Fee revenues. The decrease for primary care was partially offset with one-time tobacco cash funds in H.B. 16-1408	Personal Services 0.0% Food inflation 0.0% Medical inflation 0.0% Salary ranges were increased 2.0%, but only employee with a salary that would otherwise be below the range saw an increase	CY 15 2.8%

* State personal services increases have historically been based on the average salary survey increase for the given year plus the average of 2.2 percent through FY 2001-02 for anniversary increases. Beginning in FY 2002-03, the State shifted to a performance based pay approach (PBP). Figures shown from FY 2002-03 forward include both salary survey and PBP. These figures are for salaries and wages and do not include benefits such as health, life, and dental insurance.

** Temporary reductions to state employee compensation and personal services appropriations were taken in FY 2009-10, FY 2010-11, and FY 2011-12 as follows:

- FY 2009-10 overall reduction of 1.82 percent to General-funded personal services line items, redistributed and taken through furloughs and vacancy savings. Reduction was one-time and not base-building.
- FY 2010-11 overall reduction of 2.9 percent, based on a requirement that staff to contribute an additional 2.5 percent share of retirement (PERA) contributions and a reduction to selected General-funded personal service line items. Reductions were one-time and not base-building.
- FY 2011-12 - increased employee PERA contribution of 2.5 percent was continued in FY 2011-12, but eliminated for FY 2012-13.

MEDICAID RATE METHDOLOGY CHANGE HISTORY	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 Estimates
ACUTE CARE											
Physician Services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	Targeted rate increases for selected services	E&M Codes to 90% of Medicare rates Targeted rate increases for selected services, including: Medical Home Substance Abuse ~~Prenatal Plus~~	Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	ACA 1202 Primary Care Physician Rate Increase (Effective January 1, 2013, fiscal impact to be revised based on CMS requirements) Eff. July 2013: 2.0% increase	ACA 1202 Primary Care Physician Rate Increase (Effective January 1, 2013, fiscal impact to be revised based on CMS requirements) Eff. July 2014: 2.0% increase Pediatric/Developmental Assessment: 50% increase effective July 2014 High-Value Specialist Services to 80% of Medicare effective July 2014 Mammography Reimbursement to 80% of Medicare effective July 2014	1202 Bump continuation (Effective January 1, 2015 - provider attestation removed; these rates sunset July 1, 2016) Eff. July 2015: 0.5% increase Anesthesia - Conversion factor Increased to $28.61 (after accounting for 0.5% increase) Prenatal and Postpartum Care Services Postpartum Care (59430) - Increased to 70% of Medicare - $134.72 Antepartum Care, 4-6 Visits (59425) - Increased to 70% of Medicare - $333.17 Antepartum Care, 7+ Visits (59426) - Increased to 70% of Medicare - $596.06 Special Connections Outpatient Group Rate - increased to 97.67% of Medicaid Outpatient Rate - $29.45 Special Connectgions Per Diem Rate - increased to 88.69% of Provider Cost - $188.51 Prostate Biopsy - Increased to 49.19% of Medicare - $108.41 Diabetic Self-Management Education Visits - Group - Increased to 75% of Medicare - $11.10 Individial - Increased to 75.17% of Medicare - $40.42 Physical and Occupational Therapy Services Manual Therapy - CPT 97140 - Increased to 90% of Medicare - $27.32 Neuromuscular Re-Education - CPT 97112 - Increased to 90% of Medicare - $30.57 PT Evaluation (targeted in 2014-15) - CPT 97001** - Increased to 89.99% of Medicare - $68.88 PT Re-Evaluation (targeted in 2014-15) - CPT 97002** - Increased to 89.99% of Medicare - $38.68 Therapeutic Activities - CPT 97530 - Increased to 90.01% of Medicare - $31.89 Therapeutic Svcs (Exercise) - CPT 97110 - Increased to 89.99% of Medicare - $29.27 Vision Retinal Services REPAIR RET DETACH, ONE OR MORE SESSIONS 92250 - Increased to 74.57% of Medicare - $60.05 Special eye exam initial 92225 - Increased to 74.99% of Medicare - $20.61 Special eye exam subsequent 92226 - Increased to 75% of Medicare - $18.99 FLUORESCEIN ANGIO (MULTIFRAME) 92235 - Increased to 75% of Medicare - $84.00 FUNDUS PHOTO W/INT REPORT 67105 - Increased to 75% of Medicare - $552.44	Sunset of the original 1202 Bump continuation (rates fell to January 2012 rates) HB 16-1408: Increased a select range of codes to approximately 87.3% of the Medicare Rate	The FY 2017-18 R-6 requests to continue the increases (less of a decrease) from HB 16-1408, as they existed in FY 2016-17; the FY 2017-18 R-6 also requests to set Vaccine Stock Rates using the CDC Price List. The FY 2017-18 R-7 requests to set rates for office administered drugs to 2.5% above the average sale price on a quarterly basis.
Emergency Transportation	5% increase	(No change)	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase The following codes received approximately a 9.93% targeted rate increase OUT OF STATE AMB. MILEAGE,PER MILE A0021 - $1.46 RECIPIENT LODGING PER DAY A0180 - $39.89 RECIPIENT MEALS PER DAY A0190 - $17.56 ESCORT MEALS PER DAY A0210 - $17.56 Ambulance 02 life sustaining A0422 - $12.35 Ground mileage A0425 - $1.81 Als 1 A0426 - $110.66 ALS1-emergency A0427 - $148.71 bls A0428 - $110.59 BLS-emergency A04 - $101.90 Fixed wing air transport A0430 - $2090.65 Fixed wing air transport - modified A0430HH - $4123.49 Rotary wing air transport A0431 - $1954.08 als 2 A0433 - $178.46 Specialty care transport A0434 - $203.78 UNLISTED AMBULANCE SERVICE A0999 - $9418.69 N-et; encounter / trip T2003 - $1.86	(No Change)	(No Change)
Non-emergency Medical Transportation	31% increase in fee-for-service rates; fixed priced contracts unaffected	(No change)	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease (non metro county impact only)	(No Change)	Eff. July 2013: 2.0% increase (non metro only)	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Dental Services	(No change)	Rates set at 52% of the 2008 ADA mean	Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 4.5% increase (emergency services only)	Eff. July 2014: 2.0% increase (Adult, Children, not DIDD)	Eff. July 2015: 0.5% increase Dental X-Rays - Increased to 65% of ADA Survey Mean - $78.75 Dental Sealants for Children - Sealant per tooth D1351 - Increased to 70.46% of ADA Survey 2013 - $32.90 Dental Fillings and extractions, all listed increased to 65% of customary from ADA Surveys Amalgam - one surface, primary or permanent D2140 Amalgam - two surface, primary or permanent D2150 Amalgam - three surface, primary or permanent D2160 Amalgam - four or more surfaces, primary or permanent D2161 Resin-based composite, one surface, anterior D2330 Resin-based composite, two surfaces, anterior D2331 Resin-based composite, three surfaces, anterior D2332 Resin-based composite, four or more surfaces, anterior D2335 Resin-based composite crown, anterior D2390 Resin-based composite - one surface, posterior D2391 Resin-based composite - three surfaces, posterior D2392 Resin-based composite - two surfaces, posterior D2393 Resin-based composite - four or more surfaces, posterior D2394 Extraction, coronal remnants - deciduous tooth D7111 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) D7140 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth D7210 Removal of impacted tooth - soft tissue D7220 Removal of impacted tooth - partially bony D7230 Removal of impacted tooth - completely bony D7240 Remov Impact Tooth Comp Bony Surg Comp D7241 Surgical removal of residual tooth roots (cutting procedure) D7250 Coronectomy D7251	(No Change)	(No Change)

MEDICAID RATE METHDOLOGY CHANGE HISTORY	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 Estimates
Family Planning	Targeted rate increases for selected services	(No change)	(No change)	Eff. July 2010: 1% decrease	(No change)	(No Change)	Eff. July 2013: The greated of current rates or 105% of Medicare rates, for specific services only)	Eff. July 2014: increase specific contraceptive to $35 Increase rates for A4264, A4550, J1055/J1050, J7302, J7303, J7304, J7307 by 15% effective July 2014	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Health Maintenance Organizations	Rates at 99% of FFS One-Time Quality incentive payment added	Rates at 100% of FFS	Rates decreased commensurate with FFS reductions	Rates decreased commensurate with FFS reductions Assumed 0.80% decrease	Rates decreased commensurate with FFS reductions	(No Change)	Rates increase commensurate with FFS increases	Rates increase commensurate with FFS increases	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Inpatient Hospitals	1.5% increase	1.5% increase	Eff. July 2009: 3% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease. HB 09-1293: Hospitals paid at 100% of cost via supplemetal payments (with provider fee funds)	Eff. July 2010: 1% decrease	Reduce Payment for Uncomplicated Cesarean Section Deliveries; Reduce Payment for Renal Dialysis; Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Outpatient Hospitals	Increase to PT/OT/ST rates (Approx. 9.05%)	(No change)	Eff. July 2009: Out of state reimbursement lowered to 30% of billed charges Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease. HB 09-1293: Hospitals paid at 100% of cost via supplemetal payments (with provider fee funds)	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	Methodology Change to EAPG	(No Change)
Lab & X-Ray	(No change)	17.7% increase to Radiology services	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Durable Medical Equipment	Targeted rate increases for selected services	Targeted rate increases for selected services	Eff. July 2009: 1.97% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Reduce Rates for Certain Diabetes Supplies (blood glucose/reagent strips); Reduce rate for negative pressure wound therapy equipment Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 2.0% increase (for specific services only)	Eff. July 2014: 2.0% increase Assistive Technology Reimbursement Rate to 80% of Medicare effective July 2014	Eff. July 2015: 0.5% increase Eye Materials - All listed increased to the requested amount listed Vision svcs frames purchases V2020 - $35.01 Lens spher single plano 4.00 V2100 - $22.84 Single visn sphere 4.12-7.00 V2101 - $22.84 Singl visn sphere 7.12-20.00 V2102 - $22.84 Spherocylindr 4.00d/12-2.00d V2103 - $22.84 Spherocylindr 4.00d/2.12-4d V2104 - $28.76 Spherocylinder 4.00d/4.25-6d V2105 - $36.22 Spherocylinder 4.00d/>6.00d V2106 - $40.25 Spherocylinder 4.25d/12-2d V2107 - $28.76 Spherocylinder 4.25d/2.12-4d V2108 - $34.72 Spherocylinder 4.25d/4.25-6d V2109 - $40.25 Spherocylinder 4.25d/over 6d V2110 - $46.14 Spherocylindr 7.25d/.25-2.25 V2111 - $34.72 Spherocylindr 7.25d/2.25-4d V2112 - $40.25 Spherocylindr 7.25d/4.25-6d V2113 - $46.14 Spherocylinder over 12.00d V2114 - $52.12 Tint photochromatic lens/es V2744 - $5.14 Tint, any color/solid/grad V2745 - $5.14 Lens polycarb or equal V2784 - $6.87	(No Change)	(No Change)
Prescription Drugs*	(No change)	(No change)	Eff. July 2009: AWP - 14% (Brand), AWP - 40% (Generic) Eff. Sept. 2009: AWP - 14.5% (Brand), AWP - 45% (Generic)	(No change)	State Maximum Allowable Cost Expansion resulting in aggregate decrease in reimburement of $2,000,000 annually	AAC transition revised estimate in FY 2013-14 R-1 - $7 million reduction	Annualized impact of AAC transition $14 million reduction	Annualized impact of AAC transition $14 million reduction	(No Change)	(No Change)	(No Change)
Drug Rebate	(No change)	Implementation of PDL; Department receives supplemental rebates on preferred drugs	(No change)	(No change)	(No change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
Rural Health Centers	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2013: 1.5% increase	(No Change)	(No Change)	(No Change)
Federally Qualified Health Centers	(No change)	(No change)	Eff. Sept. 2009: Rates decreased ~5%, by adjusting to halfway between BIPA rate and Department "Alternative Rate"	(No change)	(No change)	(No Change)	Eff. July 2013: 2.0% increase	Eff. July 2014: 2.0% increase Increase rates to Alternative Payment Methodology (APM) effective July 2014	(No Change)	(No Change)	The FY 2017-18 R-6 requests to change rate methodology for FQHCs from the Alternative Payment Methodology (APM) to the Prospective Payment System (PPS) (note: the difference would be paid out to FQHCs in incentive payments)
Co-Insurance (Title XVIII-Medicare)	Per Medicare	Per Medicare	Per Medicare	Eff. July 2010: 1% decrease	(No change)	(No Change)	(No Change)	(No Change)	Eff. July 2015: 0.5% increase (indirect effect)	Indirect effect of 1202 continuation sunset/HB 16-1408	FY 2017-18 R-6 requests to continue HB 16-1408, indirect effect of HB 16-1408
Breast and Cervical Cancer Treatment Program	(No change)	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	(No Change)	(No Change)

MEDICAID RATE METHDOLOGY CHANGE HISTORY	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 Estimates
Administrative Service Organizations - Services	(No change)	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
Home Health	1.5% increase	1.5% increase	Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 8.26% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Presumptive Eligibility	End of administrative contract; claims paid fee-for-service effective January 2008	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
COMMUNITY BASED LONG TERM CARE											
HCBS - Elderly, Blind, and Disabled HCBS - Mental Illness HCBS - Persons Living with AIDS HCBS - Consumer Directed Attendant Support HCBS Spinal Cord Injury HCBS - Brain Injury HCBS - Children with Autism HCBS - Disabled Children (DIDD) HCBS-Developmental Disability Adult (DIDD) HCBS-Supported Living Services (DIDD) HCBS-CHRP (DHS) HCBS-CHCBS HCBS - Pediatric Hospice	1.5% increase Implementation of Children with Autism and Pediatric Hospice waiver.	1.5% increase, targeted increase to HCBS-DD waiver	All but DIDD:[Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.] DIDD specific - Eff Sept 2009: 2% decrease Limits to non-medical transportation trips	All but DIDD: Eff. July 2010: 1% decrease DIDD specific: Eff July 2010 2% decrease	Cap Consumer Directed Attendant Support Services Wage Rates All but DIDD - Eff. July 2011: 0.50% decrease	(No Change)	Eff. July 2013: 8.26% increase with exception of Children with Autism Waiver Eff. July 2013: 4.0% increase for DIDD, 2.0% DHS waivers	Eff. July 2014: 2.0% increase with exception of Children with Autism Waiver Eff. July 2014: 2.5% for DIDD and DHS Waivers Eff. July 2014: 191% increase for transitional living program for Brain Injury clients Pediatric Hospice Services: 20% increase effective July	Eff. July 2015: 0.5% increase for programs paid from the Medical Services Premiums Line with exception of Children with Autism Waiver, 1.7% increase for DIDD waivers Target Rate Increases varied by waiver: EBD, CMHS, SCI, and CCT Personal Care - Increased to $4.25 BI Personal Care - Increased to $4.25 CES & SLS Personal Care(1) - Increased to $4.87 EBD, CMHS, SCI, and CCT Homemaker - Increased to $4.25 CES and SLS Homemaker(1) - Increased to $4.25 (0.5% increase is not in addition to the dollar amounts listed) In-Home Respite (Excludes CES Respite) - Increased to $4.87	(No Change)	(No Change)
Private Duty Nursing	1.5% increase	1.5% increase	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 8.26% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase is included in the TRI. Home Health/PDN - PDN - RN (per hour) - increased by 84.91% of the "market" rate - $45.00	(No Change)	(No Change)
Hospice	(No change)	(No change)	(No change)	(No change)	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 8.26% increase	Eff. July 2014: 2.0% increase	Eff. July 2015: 0.5% increase (though 79% of expenditure is not eligible due to rates being directly tied to SNF rates)	(No Change) (though ~79% of expenditure is tied to SNF rates, which increase annually)	(No Change) (though ~79% of expenditure is tied to SNF rates, which increase annually)
LONG TERM CARE and INSURANCE											
Class I Nursing Facilities**	8% health care cost cap reinstated; rate floor removed. Grant program established for providers affected by the removal of the rate floor.	Comprehensive changes to NF rates (HB 08-1114). Imposition of provider fee, added pay-for-performance, severe behavorial add-on, caps on indirect health, food, and administration. Instituted General Fund cap on expenditure growth. Not effective until approval of Federal Waiver (pending)	SB 09-263: Converted add-on payments to Supplemental payments; limited GF growth to 0% in FY 2009-10; limited provider fee to $7.50; imposed 8% cap on direct and indirect health care Eff. March 2010: 1.5% rate decrease	Eff. July 2010: 1% decrease (HB 10-1379)	Eff. July 1.5% decrease (SB 11-215)	Eff. July 2012: 1.5% rate reduction (HB 12-1340)	Eff. July 2013: 1.5% permanent rate reduction (HB 13-1152)	Eff. July 2013: 1.5% permanent rate reduction (HB 13-1152)	Eff. July 2013: 1.5% permanent rate reduction (HB 13-1152)	Eff. July 2013: 1.5% permanent rate reduction (HB 13-1152)	Eff. July 2013: 1.5% permanent rate reduction (HB 13-1152)
Class II Nursing Facilities	(No change)	(No change)	(No change)	Eff. July 2010: 1% decrease	(No change)	(No change)	(No change)	(No change)	(No Change)	(No Change)	(No Change)
Program for All-Inclusive Care for the Elderly	(No change)	Rates increased to maximum of 100% FFS.	Rates decreased commensurate with FFS reductions	Rates decreased commensurate with FFS reductions Assumed 0.84% decrease	Rates decreased commensurate with FFS reductions	Eff. July 2012: Rates decrease commensurate with FFS reductions	Eff. July 2013: Rates increase commensurate with FFS increases	Eff. July 2014: Rates increase commensurate with FFS increases	Eff. July 2015: Rates increase commensurate with FFS increases	(No Change)	(No Change)
Supplemental Medicare Insurance Beneficiaries	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
Health Insurance Buy-In Program	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
SERVICE MANAGEMENT											
Single Entry Points	20.5% increase	Inflationary increase based on caseload	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	(No change)	(No Change)	(No Change)	Single Entry Point Case Management: 10% increase eff. July 2014	Eff. July 2015: 0.5% increase	(No Change)	(No Change)
Disease Management	(No change)	Disease management programs ceased in early 2009; Tobacco tax funding was used as GF offset	(No change)	(No change)	(No change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)
Administrative Service Organization/Accountable Care Collaborative Administrative Fee	(No change)	(No change)	Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	(No change)	(No change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)	(No Change)

* Presciption Drugs AWP: "Average Wholesale Price." All prescription drug claims include a dispensing fee paid to the provider, and are reduced for patient copayment. Pharmacy

**Rate reductions for this service category typically