MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	November 15, 2018
SUBJECT	Medicaid provider rate review schedule

Pursuant to statute[1], the JBC must decide by December 1 each year whether 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 whether 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. The rate reviews are intended to inform the Governor's annual budget request and the General Assembly's deliberations about funding for the Department. 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 support appropriate reimbursement of high-value services

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 exempted from review because these 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.

The Department just completed Year 3 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 4 of the rate review cycle.

The Medicaid Provider Rate Review Advisory Committee (MPPRAC) also has authority to direct a change to the rate review schedule. In the attached schedule, changes that have been adopted based on the recommendations of the MPPRAC are footnoted.

The Department presented to the MPPRAC 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 directs 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;

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

- 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.

Recommendation: The JBC staff does not recommend any modification to the rate review schedule. The JBC staff recommends allowing 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.

UPDATED: Colorado Medicaid Five Year Provider Rate Review Schedule

The Department of Health Care Policy and Financing (Department) oversees and operates Health First Colorado (Colorado's Medicaid Program), 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 compares rates paid with Medicare rates and other benchmarks, and uses 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 established the Medicaid Provider Rate Review Advisory Committee (MPRRAC), appointed by the Legislature, to assist the Department in the rate review process. The MPRRAC 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 is 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 analysis results.
Phase 4. Provide annual recommendations.

The Department submitted the original Colorado Medicaid Five Year Provider Rate Review Schedule to the Joint Budget Committee (JBC) on September 3, 2015. Both the JBC and the MPRRAC can, before December 1 of each year, direct the Department to review services out of cycle of the rate review schedule. This document updates the original rate review schedule, to include changes to the schedule recommended by the MPRRAC. If further directed by the JBC to review a service out of cycle, the Department may make changes to the schedule to accommodate the additional work and analyses associated with the out-of-cycle review.

Rate Review Schedule

Services are listed for each year of the five-year cycle. Services are listed by broad categories of service, and if applicable, by further sub-category of service.

Year One (December 2015 – November 2016)

Laboratory and Pathology Services
Home Health Services
Private Duty Nursing
Non-Emergent Medical Transportation (NEMT)
Emergency Medical Transportation (EMT)
Physician-Administered Drugs

Year Two (September 2016 – November 2017)

Physician Services[1]

- Ophthalmology
- Speech Therapy
- Cardiology
- Cognitive Capabilities Assessment
- Vascular
- Respiratory
- Ear, Nose, and Throat
- Gastroenterology

Surgery

- Digestive System
- Musculoskeletal System
- Cardiovascular System
- Integumentary System
- Eye and Auditory System
- Respiratory System

Anesthesia

Home- and Community-Based Service (HCBS) Waivers

- Waiver for Persons Who are Elderly, Blind, and Disabled (EBD Waiver)
- Community Mental Health Supports Waiver (CMHS Waiver)
- Waiver for Persons with Brain Injury (BI Waiver)
- Waiver for Persons with Spinal Cord Injury (SCI Waiver)
- Children's HCBS Waiver (CHCBS Waiver)
- Waiver for Children with Autism (CWA Waiver)
- Waiver for Children with Life-Limiting Illness (CLLI Waiver)
- Children's Extensive Supports Waiver (CES Waiver)
- Children's Habilitation Residential Program Waiver (CHRP Waiver)
- Waiver for Persons with Developmental Disabilities (DD Waiver)
- Supported Living Supports Waiver (SLS Waiver)

Targeted Case Management

[1] The MPRRAC voted to move **End-Stage Renal Disease (ESRD) and Dialysis** from year two, within physician services, to year four, to be analyzed with other dialysis services.

Year Three (September 2017 – November 2018)

Physician Services[2]

- Primary Care and Evaluation & Management Services, including:
    - Evaluation and Management (E&M) Services
    - Vaccines and Immunizations
    - Family Planning Codes
    - Alternative Payment Methodology (APM) Codes
- Radiology
- Physical and Occupational Therapy
- Other Physician Services and Procedures, including:
    - Allergy Services
    - Neurology Services
    - Sleep Studies
    - Skin Procedures
    - Genetic Counseling
    - Miscellaneous Services

Surgery

- Maternity Services
- Other Surgeries, including:
    - Genital System
    - Nervous System
    - Urinary System
    - Endocrine System

Dental Services

Year Four (September 2018 – November 2019)

Ambulatory Surgical Centers
Health and Behavior Assessment[3]
Residential Child Care Facilities (RCCF), Therapeutic RCCF (TRCCF), and Psychiatric Residential Treatment Facilities (PRTF)
Dialysis and End-Stage Renal Disease Services
Durable Medical Equipment

Year Five (September 2019 – November 2020)

Prosthetics
Eyeglasses
Disposable Supplies

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[2] The Department is examining **Family Planning** in year three, instead of year four, because the majority of services within that sub-category of service have already been reviewed, or are scheduled for review in year three, under a different category of service. The Department is also reviewing all codes within the **Primary Care Alternative Payment Methodology (APM)** code set in year three because many services within the code set were previously scheduled for review in year three.
[3] The Department is examining **Health and Behavior Assessment** in year four, instead of year three, because other behavioral health services are scheduled to be examined in year four; this includes RCCF, TRCCF, and PRTF.

The Department proposes to maintain capacity in Year Five to accommodate the need to evaluate new benefits, off-cycle reviews directed by the JBC or the MPRRAC, codes that do not fit under previously reviewed categories and sub-categories of service, and reviews required by new statutory and/or regulatory mandates.

Excluded Rates

The Department recommended to exclude certain service categories from the rate review process. Service categories were generally excluded 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. The Department has not made any additions to the original list of excluded rates, outlined below.

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 provider performance in meeting a set of quality indicators specific to the contracted group.

Contracted Plans:

Contracted Health Maintenance Organizations (HMO) and Behavioral Health Organizations (BHO)[4] are reimbursed based on an annually-calculated per-member per-month, or capitated, rate. Capitated rates are reviewed annually by actuaries, contractually stipulated, and are updated during each contract renewal period. The contract includes a table of actuarially-computed rates that the Department will pay.

Selected Regular Rate Setting Work:

Inpatient Hospitals[5]**:** 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. The latest update to the weights was completed for the July 1, 2016 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 Hospitals[6]: A prospective payment methodology – Enhanced Ambulatory Patient Grouping (EAPG) System – was implemented for outpatient hospital services in November 2016. Similar to inpatient hospital reimbursement, specific cost information is included in the rate to account for cost variation across providers. Transportation, which was not affected by the EAPG transition, remains under the current fee schedule payment methodology.

[4] 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
[5] 10 CCR 2505-10 Section 8.300.5; CRS 25.25-4-402
[6] 10 CCR 2505-10 Section 8.300.6

Clinic*:*

Federally Qualified Health Centers (FQHCs)[7] *and Regional Health Centers (RHCs)*[8]*:* FQHCs and RHCs 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, updated annually.

School Based Clinic Services[9] *and School Based Clinic Case Management*[10]**:** These services are reimbursed at cost. Rates are based on a per-unit reimbursement, reconciled annually through a cost settlement.

Facility:

Nursing Facility[11] *Class I and Class V:* Nursing facility reimbursement is governed by statute 25.5-600.2 which 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)[12] *Class II and Class IV:* ICF/IID reimbursement is governed by statute 25.5-600.2 which requires that rates are updated annually and based on costs reported by facilities each July 1.

Prescribed Drugs:[13]

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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[7] 10 CCR 2505-10 Section 8.700
[8] 10 CCR 2505-10 Section 8.740
[9] 10 CCR 2505-10 Section 8.290.6 -8.290.8; CRS 25.5-5-318
[10] Ibid
[11] 10 CCR 2505-10 Section 8.443; CRS 25.5-6-201; CRS 25.5-6-202
[12] CRS 25.5-6-204
[13] 10 CCR 2505-10 Section 8.800.13