MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	November 14, 2019
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.

REVIEW PROCESS

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. Rates subject to review must be reviewed at least once every five years. The Department may exempt rates from review because the rates are adjusted periodically based on costs, adjusted periodically based on another state or federal law or regulation, or are payments unrelated to a specific service rate. The rate reviews are conducted with input from the Medicaid Provider Rate Review Advisory Committee (MPRRAC). In addition to the JBC, the MPRRAC also has authority to direct a change to the rate review schedule. 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 just completed Year 4 of the rate review cycle. A report was submitted May 2019 summarizing the Department's findings and another report in November 2019 summarizing the Department's recommendations. These reports will be discussed during the budget briefing. The Department is about to begin Year 5 of the rate review cycle.

REVIEW SCHEDULE

The Department recently revamped the rate review schedule. In the original plan the workload during Year 5 was intentionally light to maintain flexibility for unexpected changes to the review schedule, either for policy or technical reasons. Now, with a better understanding of the work involved, the Department is rebalancing the schedule to spread the labor more evenly across the five years. In addition, the Department proposes shifting service groupings to more closely align with related services, adding and removing services for review, and adjusting the schedule based on feedback received and lessons learned. The schedule changes were approved by the MPRRAC in June 2019.

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

The revised schedule is attached at the end of this memo. The following is the Department's summary of the changes and the rationale.

SERVICES REMOVED FROM THE SCHEDULE

The following services have been removed from the Rate Review Five-Year Schedule:

- Waiver for Children with Autism (CWA Waiver)
  - The CWA Waiver is no longer an active waiver.
- Physician Administered Drugs (PADs)
  - PADs were moved under pharmacy, which has its own review process.
- End Stage Renal Disease (ESRD)
  - ESRD is a diagnosis, not a service; Nephrology has been included with dialysis services instead.
- Health and Behavior Assessment
  - Health and Behavior Assessment services are not reimbursed by Medicaid.

SERVICES ADDED TO THE SCHEDULE

The following services have been added to the Rate Review Schedule; many of which became covered services post-creation of the original schedule:

- Injections and other Miscellaneous J-Codes
  - Added to Year Two with other physician specialty services.
- Health Education Services
  - Added to Year Two with other physician services.
  - Includes some codes that have previously been reviewed, and some which have not been previously reviewed.
  - Added to the schedule to align with other Department initiatives being brought to the Medical Services Board.
- Prenatal Plus
  - Added to Year Three with other maternity and like services.
- Pediatric Behavioral Therapy
  - Added to Year Five with other pediatric and home-based services.
  - Suggested for rate review by stakeholders.
- Pediatric Personal Care
  - Added to Year Five with other pediatric and home-based services.

SERVICES MOVED TO ANOTHER YEAR OF REVIEW

The following services were moved to a different year of the five-year rate review cycle:

- Home and Community-Based Services Waivers
  - Due to the high volume of stakeholder feedback during the first review cycle, HCBS Waivers were moved from Year Two to Year One of the rate review cycle to isolate HCBS waivers into their own year.
- Physician Services
  - To consolidate most physician services into the same year of review, the following services were moved from Year Three to Year Two: Radiology, Primary Care, E&M, Vaccines and Immunizations, Family Planning Services, and miscellaneous physician services.

- Dialysis and Nephrology Services
  - To better align like services, Dialysis and Nephrology services were moved from Year Four to Year Two.
- Laboratory and Pathology Services
  - To better align like services, Laboratory and Pathology services were moved from Year One to Year Two.
- Eyeglasses
  - To better align like services, Eyeglasses were moved from Year Five to Year Two, to be reviewed at the same time as Ophthalmology.
- Dental Services
  - To balance out the workload for each year of the review, Dental Services were moved from Year Three to Year Four.
- Special Connections Program Services
  - To better align like services, Special Connections Program Services were moved from Year Four to Year Three, to be reviewed at the same time as Maternity Services, Prenatal Plus, and the Nurse Home Visitor Program.
- Disposable Supplies, Prosthetics, and Orthotics
  - To better align like services, Disposable Supplies, Prosthetics, and Orthotics were moved from Year Five to Year Four, to be reviewed at the same time as Durable Medical Equipment.
- Home Health Services and Private Duty Nursing
  - To better align like services and balance the workload for each year of the review, Home Health Services and Private Duty Nursing were moved from Year One to Year Five, and as a result will be reviewed sooner.
- Physician Services: Speech Therapy and Physical and Occupational Therapy
  - To better align like services: Speech Therapy Physician Services were moved from Year Two to Year Five and as a result will be reviewed sooner; and Physical and Occupational Therapy Physician Services were moved from Year Three to Year Five.

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, and a revised schedule on November 9, 2017. This document updates the revised schedule, to reflect the planned rate review schedule for years six through ten of the process. 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. 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 (July 2020 – November 2021)

Home and Community Based Services Waivers	
Waiver for Persons Who are Elderly, Blind, and Disabled (EBD Waiver)	Waiver for Persons with Spinal Cord Injury (SCI Waiver)
Community Mental Health Supports Waiver (CMHS Waiver)	Children's Habilitation Residential Program Waiver (CHRP Waiver)
Waiver for Persons with Brain Injury (BI Waiver)	Children's HCBS Waiver (CHCBS Waiver)
Children's Extensive Supports Waiver (CES Waiver)	Supported Living Supports Waiver (SLS Waiver)
Waiver for Persons with Developmental Disabilities (DD Waiver)	Waiver for Children with Life-Limiting Illness (CLLI Waiver)
Targeted Case Management (TCM)	
Non-Emergent Medical Transportation (NEMT)	
Emergency Medical Transportation (EMT)	

Year Two (July 2021 – November 2022)

Dialysis and Nephrology	
Laboratory and Pathology Services	
Eyeglasses	
Injections and other Miscellaneous J-Codes	
Physician Services	
Ophthalmology	Respiratory
Cardiology	Ear, Nose, and Throat
Cognitive Capabilities Assessment	Gastoenterology
Vascular	Endocrinology
Radiology	Vaccines and Immunizations
Primary Care and Evaluation and Management Services	Health Education Services
Women's Health and Family Planning Services	Other Physician Services

Year Three (July 2022 – November 2023)

Anesthesia	
Ambulatory Surgical Centers	
Maternity Services: surgery and other services	
Surgery	
Digestive System	Integumentary System
Musculoskeletal System	Eye and Auditory System
Cardiovascular System	Other Surgeries
Respiratory System	
Special Connections	
Prenatal Plus	

Year Four (July 2023 – November 2024)

Dental Services
Fee-for-Service Behavioral Health Services
Residential Child Care Facilities (RCCFs)
Psychiatric Residential Treatment Facilities (PRTFs)
Durable Medical Equipment (non-UPL)
Disposable Supplies
Prosthetics
Orthotics

Year Five (July 2019 – November 2020; July 2024 – November 2025)

Pediatric Behavioral Therapy
Pediatric Personal Care
Home Health Services
Private Duty Nursing
Speech Therapy
Physical and Occupational Therapy

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)[1] 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[2]**:** 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[3]: 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.

[1] 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
[2] 10 CCR 2505-10 Section 8.300.5; CRS 25.25-4-402
[3] 10 CCR 2505-10 Section 8.300.6

Transportation, which was not affected by the EAPG transition, remains under the current fee schedule payment methodology.

Clinic*:*

Federally Qualified Health Centers (FQHCs)[4] *and Regional Health Centers (RHCs)*[5]*:* 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[6] *and School Based Clinic Case Management*[7]**:** These services are reimbursed at cost. Rates are based on a per-unit reimbursement, reconciled annually through a cost settlement.

Facility:

Nursing Facility[8] *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)[9] *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:[10]

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

[4] 10 CCR 2505-10 Section 8.700
[5] 10 CCR 2505-10 Section 8.740
[6] 10 CCR 2505-10 Section 8.290.6 -8.290.8; CRS 25.5-5-318
[7] Ibid
[8] 10 CCR 2505-10 Section 8.443; CRS 25.5-6-201; CRS 25.5-6-202
[9] CRS 25.5-6-204
[10] 10 CCR 2505-10 Section 8.800.13