COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2019

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Joint Budget Committee on the Medicaid Provider Rate Review Recommendation Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Ambulatory Surgical Centers (ASCs), Fee-for-Service (FFS) behavioral health services, Residential Child Care Facilities (RCCFs), Psychiatric Residential Treatment Facilities (PRTFs), Special Connections Program services, Dialysis and End-Stage Renal Disease (ESRD) treatment services, and Durable Medical Equipment (DME) under review in year four of the rate review process.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2019 Medicaid Provider Rate Review Recommendation Report

CC: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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John Bartholomew, Finance Office Director, HCPF
Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Stephanie Ziegler, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2019

Wilson Pace, Chair
Medicaid Provider Rate Review Advisory Committee
303 East 17th Avenue
Denver, CO 80203

Dear Mr. Pace:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Medicaid Provider Rate Review Advisory Committee on the Medicaid Provider Rate Review Recommendation Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Ambulatory Surgical Centers (ASCs), Fee-for-Service (FFS) behavioral health services, Residential Child Care Facilities (RCCFs), Psychiatric Residential Treatment Facilities (PRTFs), Special Connections Program services, Dialysis and End-Stage Renal Disease (ESRD) treatment services, and Durable Medical Equipment (DME) under review in year four of the rate review process.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2019 Medicaid Provider Rate Review Recommendation Report

CC: Tim Dienst, Medicaid Provider Rate Review Advisory Committee
David Friedenson, Medicaid Provider Rate Review Advisory Committee
Chris Hinds, Medicaid Provider Rate Review Advisory Committee
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Nina Schwartz, Legislative Liaison, HCPF

2019 Medicaid Provider Rate Review Recommendation Report

November 1, 2019

Submitted to: The Joint Budget Committee and the Medicaid Provider Rate Review Advisory Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Executive Summary 3

Ambulatory Surgical Centers (ASCs) 3

Fee-for-Service (FFS) Behavioral Health Services 4

Residential Child Care Facilities (RCCFs) 4

Psychiatric Residential Treatment Facilities (PRTFs) 5

Special Connections Program Services 5

Dialysis and End-Stage Renal Disease (ESRD) Treatment Services 5

Durable Medical Equipment (DME) 6

II. Introduction 6

Background 6

Report Purpose 7

MPRRAC Guiding Principles 7

Report Format 7

III. Year Four Recommendations 8

Ambulatory Surgical Centers (ASCs) 8

Fee-for Service (FFS) Behavioral Health Services 9

Residential Child Care Facilities (RCCFs) 10

Psychiatric Residential Treatment Facilities (PRTFs) 12

Special Connections Program Services 13

Dialysis and End-Stage Renal Disease (ESRD) Treatment Services 14

Durable Medical Equipment (DME) 16

COLORADO
Department of Health Care Policy & Financing

I. Executive Summary

This report contains the work of the Colorado Department of Health Care Policy & Financing (the Department) to review rates paid to providers under the Colorado Medical Assistance Act, and the Department's findings and recommendations for seven broad categories of service and programs:

- Ambulatory Surgical Centers (ASCs),
- Fee-for-Service (FFS) Behavioral Health services,
- Residential Child Care Facilities (RCCFs),
- Psychiatric Residential Treatment Facilities (PRTFs),
- Special Connections Program services,
- Dialysis and end-stage renal disease (ESRD) treatment services, and
- Durable Medical Equipment (DME).

The rate review process was informed by rate benchmark comparisons, access analyses, stakeholder feedback, and Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback.

Medicare rates were used as the primary rate benchmark comparison for four of the seven categories of service and programs: ASCs, FFS Behavioral Health services, dialysis and ESRD treatment services, and DME. Service rates paid by an average of comparable Medicaid states were used as the benchmark comparison for PRTFs, RCCFs, and Special Connections Program services, as well as some ASC, FFS Behavioral Health services, dialysis and ESRD treatment services, and DME rates, where appropriate.[1]

Ambulatory Surgical Centers (ASCs)

Payment rates for ASCs were 63.95% of the benchmark. Rate benchmark comparisons varied widely; payments for the ten ASC code grouping rate ratios varied between 29.71% and 139.02% of the benchmark.

Department Recommendations

1. Add clinically appropriate procedure codes to the list of services that can be reimbursed in an ASC setting.
2. Eliminate the ASC grouping reimbursement methodology in favor of a more appropriate reimbursement methodology.[2]

[1] For more information regarding benchmarks, including benchmark descriptions and methodologies, see the 2019 Medicaid Provider Rate Review Analysis Report.
[2] This recommendation may require additional resources, such as contracting funds.

3. Re-evaluate each service rate relative to the benchmark and evaluate individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[3]
4. Evaluate the potential for creating a Multiple Procedure Discounting reimbursement methodology.[4]
5. Conduct additional evaluation of whether costs can be offset by incentivizing migration of appropriate procedures from the hospital to the ASC setting.

Fee-for-Service (FFS) Behavioral Health Services

Payment rates for FFS Behavioral Health services were 94.67% of the benchmark. Rate benchmark comparison varied widely; payments varied between 22.71% and 231.23% of the benchmark.

Department Recommendation

1. Evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[5]

Residential Child Care Facilities (RCCFs)

Payment rates for RCCFs were 68.56% of the benchmark. Rate benchmark comparison varied widely; payments varied between 47.00% and 100.64% of the benchmark.

Department Recommendations

1. Evaluate methods to differentiate payments for RCCFs from other FFS Behavioral Health services.
2. Initiate a joint RCCF and PRTF rate setting project using Department best practices to incentivize proper use of each facility type.[6]
3. Evaluate the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

[3] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[4] This recommendation may require additional resources, such as contracting funds.
[5] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[6] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.

Psychiatric Residential Treatment Facilities (PRTFs)

Payment rates for PRTFs were 114.36% of the benchmark.[7]

Department Recommendation

1. Initiate a joint RCCF and PRTF rate setting project using Department best practices to incentivize proper use of each facility type.[8]
2. Evaluate the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

Special Connections Program Services

The per diem rate for Special Connections Program services was 114.54% of the benchmark. The other rate benchmark comparisons varied widely; payments varied between 9.78% and 630.72% of the benchmark.

Department Recommendations

1. Further align with and support Office of Behavioral Health (OBH) efforts to increase data availability, consistency, and validity.
2. Further evaluate whether initiating a rate setting project would be beneficial.[9]
3. Conduct a provider survey to augment data currently available and to identify areas for impacting program improvement.

Dialysis and End-Stage Renal Disease (ESRD) Treatment Services

Payment rates for dialysis and ESRD treatment services were 83.26% of the benchmark. Payments varied between 73.46% and 90.02% of the benchmark.

Department Recommendations

1. Evaluate potential reimbursement method changes for in-home Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis services, which would align more closely with the Medicare payment methodology.
2. Evaluate factors that impact utilization of in-home dialysis, including Medicare enrollment, and methods to improve access to in-home dialysis options where appropriate.

[7] There is only one per diem rate for PRTFs.
[8] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.
[9] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.

Durable Medical Equipment (DME)

Payment rates for DME not subject to Upper Payment Limits (UPL)[10] were 104.84% of the benchmark. Rate benchmark comparison varied widely; payments varied between 3.9% and 1,478% of the benchmark.

Department Recommendations

1. Evaluate individual services not subject to the UPL that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[11]
2. Continue access to care evaluation of DME services subject to the UPL and work with state and federal partners to identify solutions to impacted services.
3. Evaluate the benefit of DME service component reimbursement.[12]

II. Introduction

Background

In 2015, the General Assembly adopted Senate Bill 15-228 "Medicaid Provider Rate Review," which created a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with section 25.5-4-401.5, C.R.S., the Department established a rate review process that involves four components:

- Assess and, if needed, review a five-year schedule of rates under review;
- Conduct analyses of service, utilization, access, quality, and rate comparisons to an appropriate benchmark for services under review and present the findings in a report published the first of every May;
- Develop strategies for responding to the analyses results; and
- Provide recommendations on all rates reviewed and present in a report published the first of every November.

In accordance with the statute, the Department also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC), which assists the Department in the review of provider rate reimbursements.

Services under review this year, Year Four of the five-year rate review process, include:

- Ambulatory Surgical Centers (ASCs)
- FFS Behavioral Health services
- Residential Child Care Facilities (RCCFs)
- Psychiatric Residential Treatment Facilities (PRTFs)
- Special Connections Program services

[10] Payment rates for DME subject to UPL were 100% of the benchmark (Medicare).
[11] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[12] This recommendation was added in response to MPRRAC and stakeholder feedback.

- Dialysis and end-stage renal disease (ESRD) treatment services
- Durable Medical Equipment (DME)

On May 1, 2019, the Department published the 2019 Medicaid Provider Rate Review Analysis Report.

Report Purpose

This document serves as the second report in the annual rate review process. It briefly summarizes what was learned through the rate review process, considerations, and the Department's recommendations for services reviewed in Year Four. The Department's recommendations were informed by the 2019 Medicaid Provider Rate Review Analysis Report, as well as MPRRAC and stakeholder feedback. They were developed after working with the Office of State Planning and Budgeting to determine priorities and achievable goals within the statewide budget.

This report is intended to be used by the Joint Budget Committee (JBC) for consideration in formulating the budget for the Department.

MPRRAC Guiding Principles

The MPRRAC and the Department share the goal of using the rate review process to critically analyze rates, member access, provider retention, and develop appropriate recommendations. During Year One of the rate review process, the MPRRAC identified a series of overarching guiding principles to guide their evaluation of Department-presented information and discussions. Those guiding principles were used again during Year Four:

- "Don't reinvent the wheel"; if an appropriate rate benchmark or rate setting methodology exists, try to use it.
- Support rates and methodologies that encourage care to be delivered in the least restrictive and least costly environment.
- Develop methodologies to account for the differences in delivering services in geographically different settings, especially rural settings.
- Rates and methodologies should attempt to cover the direct costs of goods and supplies for providers.

Report Format

This report is separated into seven sections: ASCs, FFS Behavioral Health services, RCCFs, PRTFs, Special Connections Program services, dialysis and ESRD treatment services, and DME. Each section contains:

- Summary of Findings – a summary of the Department's findings through the rate review process, which includes rate comparison and access analyses;
- Considerations – including information and data that informed the development of the Department's recommendations; and
- Department Recommendations.

III. Year Four Recommendations

Ambulatory Surgical Centers (ASCs)

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for ASCs were 63.95% of the benchmark. Rate benchmark comparisons varied widely; payments for the ten ASC code grouping rate ratios varied between 29.71% and 139.02% of the benchmark.[13,14] Analyses suggest that ASC payments were sufficient to allow for member access and provider retention. However, additional research may reveal more information that could lead to a different conclusion.[15]

Considerations

Medicare reimburses more services in ASC settings than Colorado Medicaid. The Department is aware that care is sometimes provided in a hospital setting that could be provided in an ASC. As a result, the Department is evaluating additional services for reimbursement in an ASC setting.[16] The Department is also further analyzing the potential for cost savings if more procedures were reimbursed in ASC settings compared to those currently reimbursed in outpatient hospital settings, as suggested by stakeholders. The Department will evaluate the findings of the Medicaid Evidence-based Decisions Project (MED) analysis of best practices for migrating appropriate care from the hospital to the ASC setting. This is being researched on behalf of participating states and will be completed later in 2019. The Department considers that, at times, it is more appropriate for certain procedures to be conducted in the hospital setting (e.g., when members present as medically complex).

In addition, Medicare practices Multiple Procedure Discounting (MPD), but Colorado Medicaid does not. Stakeholders indicated that providers often choose between the following two options:

- Perform procedures at different times to be reimbursed for each procedure individually; or
- Perform multiple procedures at a single appointment to only be reimbursed for the most complex procedure.

The MPRRAC and stakeholders noted their support of the recommendations below.

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[13] Services performed at an ASC are assigned to one of ten rate group brackets for reimbursement. If multiple procedures are provided in a single visit, they are grouped together, and reimbursement is based on the most complex procedure.

[14] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; detailed information regarding the rate comparison analysis methodology is contained in Appendix B; visual representations of variations in the rate benchmark comparisons and access to care analyses are contained in Appendix C of the report.

[15] The Department recognizes that while analyses indicate that member access and provider retention are sufficient, there are ways in which access to ASC services could be improved.

[16] A working list of codes is currently being reviewed from a clinical and academic perspective to determine a final list of procedures to allow for reimbursement in ASC settings. To develop this list, a crosswalk was completed of covered Medicare and Medicaid ASC services to identify codes that Medicare reimburses in ASC settings that Medicaid does not; next, Medicaid non-covered services were excluded; finally, services determined to be unsafe to perform in ASC settings were excluded (e.g., spinal and vascular surgeries).

Department Recommendations

1. Add clinically appropriate procedure codes to the list of services that can be reimbursed in an ASC setting.[17]
2. Eliminate the ASC grouping reimbursement methodology in favor of a more appropriate reimbursement methodology.[18]
3. Re-evaluate each service rate relative to the benchmark and evaluate individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[19]
4. Evaluate the potential for creating a Multiple Procedure Discounting reimbursement methodology.[20]
5. Conduct additional evaluation of whether costs can be offset by incentivizing migration of appropriate procedures from the hospital to the ASC setting.

Fee-for-Service (FFS) Behavioral Health Services

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for FFS behavioral health services were 94.67% of the benchmark. Rate benchmark comparison varied widely; payments varied between 22.71% and 231.23% of the benchmark.[21] Analyses suggest that FFS Behavioral Health payments were sufficient to allow for member access and provider retention.

Considerations

The Department contracts with the Regional Accountable Entities (RAEs), which are the primary access point for behavioral health services. Under a separate managed care arrangement, the Department pays a fixed, capitated rate to the RAEs to manage and reimburse for the vast majority of behavioral health services Colorado Medicaid members receive. Each RAE contracts with behavioral health providers within their region and has the flexibility to negotiate reimbursement rates with each of those providers. For services covered under the RAE contracts, behavioral health providers bill the RAEs directly for services rendered.[22] Capitated rates

[17] This recommendation aligns with the Governor's November 1, 2019 executive budget request R-10, "Provider Rate Adjustments."
[18] This recommendation may require additional resources, such as contracting funds.
[19] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[20] This recommendation may require additional resources, such as contracting funds.
[21] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; detailed rate comparison results are contained in Appendix B of the report; visual representations of variations in the rate benchmark comparisons and access to care analyses are contained in Appendix C of the report.
[22] RAE contracts include a list of covered diagnoses. Where a diagnosis is not part of the RAE contract, providers bill the Department directly for behavioral health services rendered. For example, in FY 2017, 97,000 claims for general psychotherapy services were reimbursed by RAEs, compared to 8,000 claims that were reimbursed FFS.

reimbursed through the RAEs are not included in the FFS Behavioral Health services analyzed within the 2019 Medicaid Provider Rate Review Analysis Report; only FFS behavioral health rates were included in the report.

Subsequent to the period of review, the Department took independent action to increase the rate for code 90792, Psychiatric Diagnostic Evaluation with Medical Services, to 100% of the national Medicare non-facility rate.

The MPRRAC and stakeholders noted their support of the recommendation below.

Department Recommendations

1. Evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[23, 24]

Residential Child Care Facilities (RCCFs)

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for RCCFs were 68.56% of the benchmark. Rate benchmark comparison varied widely; payments varied between 47.00% and 100.64% of the benchmark.[25] Analyses were inconclusive to determine if RCCF payments were sufficient to allow for member access and provider retention.

Considerations

RCCF services are part of a child welfare services continuum; counties place members into an RCCF when other child welfare services (such as group home placement) are inadequate to meet the need of the member. The Department reimburses RCCF services in accordance with the behavioral health fee schedule;[26] the Department does not pay differently based on place of service.[27] RCCFs have evolved over time to serve higher acuity children. However, because RCCF settings serve children with high acuity needs, the level of staffing and type of clinicians needed to provide services in an RCCF often exceeds what is required when those same services

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When behavioral health providers bill the Department directly, the Department reimburses providers based on behavioral health service rates listed in the Colorado Medicaid Fee Schedule.

[23] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

[24] This recommendation aligns with the Governor's November 1, 2019 executive budget request R-10, "Provider Rate Adjustments."

[25] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; detailed rate comparison results are contained in Appendix B of the report; visual representations of variations in the rate benchmark comparisons and access to care analyses are contained in Appendix C of the report.

[26] Room and board are funded by the county placing the member into the facility.

[27] RCCF providers are reimbursed a facility rate by the county. Counties place members into RCCFs and negotiate the facility rate with RCCF providers.

are provided to members outside an RCCF setting. Medication management in RCCF settings must also be considered as it differs from medication management elsewhere. For example, there is a need for specialized psychiatric prescribers; however, Medicaid pays one rate for medication management regardless of setting. The Department is considering the totality of services provided in RCCFs in terms of rate setting, based on the services provided by RCCFs for higher complexity cases and the expansion of their scope of practice to care for children needing 24-hour medical services. The Department will also consider the utilization of other services across the continuum of care, as well as state initiatives to decrease residential-based treatments and increase home and community-based services.

The federal Family First Prevention Services Act (FFPSA)[28] passed on February 9, 2018, created the Qualified Residential Treatment Program (QRTP), which is projected to be implemented in January 2020. QRTPs must meet federal requirements including 24-hour access to medical care. The Department anticipates that many RCCFs will seek QRTP certification. It is unknown how the QRTP certification will affect access to care.

Finally, the state has a strong focus on prevention of out-of-home placement, which may mitigate the number of needed RCCF placements. For example, the Family Services Improvement and Innovation Act[29] enabled states to operate a coordinated program of family preservation and community-based family support services designed to help families alleviate crises and maintain the safety of children in their own homes. Also, a Colorado Title IV-E Waiver Demonstration Project[30] coordinated through the Colorado Department of Human Services and scheduled to sunset in September 2019[31] enabled child welfare agencies to use block allocation funding to prevent foster care entry, increase permanency, prevent short stays in placement, and reduce/prevent placement reentry.

The MPRRAC and stakeholders noted their support of the recommendations below.

Department Recommendations

1. Evaluate methods to differentiate payments for RCCFs from other FFS Behavioral Health services.
2. Initiate a joint RCCF and PRTF rate setting project using Department best practices to incentivize proper use of each facility type.[32]

[28] H.R.253; aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skills training. It also seeks to improve the wellbeing of children already in foster care by incentivizing states to reduce placement of children in congregate care.
[29] P.L.112-34; reauthorized the Promoting Safe and Stable Families and Child Welfare Services program through FY 2016.
[30] For more information, see the Profiles of the Active Title IV-E Child Welfare Demonstrations, p.20-25.
[31] These funds will be replaced by funding through the federal Family First Prevention Services Act (see footnote 26); it is unclear at this time whether certain demonstration activities and associated funding will continue.
[32] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.

3. Evaluate the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

Psychiatric Residential Treatment Facilities (PRTFs)

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for PRTFs were 114.36% of the benchmark. [33,34] Analyses were inconclusive to determine if PRTF payments were sufficient to allow for member access and provider retention.

Considerations

PRTFs treat high acuity individuals who need 24-hour access to medical services. The Department is considering the totality of services provided in PRTFs in terms of rate setting, based on the services provided by PRTFs for higher complexity cases.

Colorado Medicaid reimbursed one PRTF July 2015-March 2018.[35] The Department recognizes that additional research is needed to fully understand why utilization of PRTFs in Colorado is low. The Department is performing ongoing PRTF analyses in alignment with the implementation of federal regulations; refer to the RCCF Considerations section above for examples of the state initiatives focused on prevention of out-of-home placement, which may mitigate the number of PRTF placements. The Department is also conducting further analysis to quantify the extent to which reimbursement of services in RCCF settings differs from the PRTF per diem rate.

In addition, the Department received feedback from the sole PRTF billing provider that the PRTF per diem rate is insufficient to cover operational costs.

The MPRRAC and stakeholders noted their support of the recommendations below.

Department Recommendations

1. Initiate a joint RCCF and PRTF rate setting project using Department best practices to incentivize proper use of each facility type.[36]

2. Evaluate the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

[33] There is only one per diem rate for PRTFs.
[34] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; visual representations of variations in the rate benchmark comparisons are contained in Appendix C of the report.
[35] This information comes from limited claims data pulled for targeted claims used in the 2019 Medicaid Provider Rate Review Analysis Report.
[36] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.

Special Connections Program Services

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed the per diem rate for the Special Connections Program was 114.54% of the benchmark. The other rate benchmark comparisons varied widely by individual service; payments varied between 9.78% and 630.72% of the benchmark.[37,38] Analyses are inconclusive to determine if Special Connections payments were sufficient to allow for member access and provider retention.

Considerations

The Department is aware of legislation that will impact access for pregnant and parenting mothers, including HB19-1193, which will expand the eligibility period for Special Connections to include postnatal members, and SB19-228, which will further integrate substance use disorder (SUD) treatment and obstetrics and gynecology (OB/GYN) services (e.g., employing OB/GYN providers in SUD treatment centers and SUD treatment professionals in OB/GYN settings).

In addition, the Department received feedback from stakeholders, both through the rate review process and through other feedback channels, which included, but is not limited to: [39,40]

- Current Special Connections service rates are too low for program sustainability; the program requires providers with specialized qualifications.
- There are access issues due to the restrictions on program eligibility.[41]
- There are difficulties providing residential services for pregnant women with dependent children.[42]
- The operational challenges for these programs and the treatments provided by these programs tend to be complex in nature. Accommodating the family unit within a treatment setting is one example and can be associated with longer clinical hours, higher levels of staff specialty, and higher costs for treatment in general.
- Childcare costs are not included in Colorado Medicaid Special Connections rates; however, the FFPSA could provide this for members who have child welfare involvement at $54 per diem for the child's costs.
- Federal regulations limit institutes of mental disease to 16 beds per site.

[37] The Department does not currently have claims data from the Special Connections Program; the implementation of a new claims payment system and the associated rule change to include a new, isolated provided type interfered with claims data submission. The lack of claims data impacted the rate comparison analysis; reimbursement rates were compared to estimated benchmarks for each code using comparable sources (i.e. other states' Medicaid programs).
[38] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; additional rate comparison data for the top procedure codes are located in Appendix C of the report.
[39] Department subject matter experts (SMEs) shared additional feedback they received from various stakeholders prior to the March 29, 2019 MPRRAC meeting.
[40] Refer to page 36 of the 2019 Medicaid Provider Rate Review Analysis Report for a comprehensive list of stakeholder feedback received prior to and during the rate review process.
[41] Mothers must enroll prenatally to access post-partum services offered up to a year after giving birth.
[42] Mothers who have other dependent children require more resources in residential settings.

- There are only 56 beds available statewide for various programs across multiple payors; these are not limited to Special Connections Program participants.
- Providers consider medical complexity, associated need for child-care, and whether additional beds will be occupied by dependent children when determining enrollment of Special Connections participants compared to non-Special Connections participants.
- Reimbursement rates for outpatient SUD services negotiated through the RAEs are higher than the rate for similar outpatient services through the Special Connections program.
- The cost of treatment can range from $392 to $417 per day, but the current per diem rate for Special Connections services is set at $192 per day. This low rate is prohibiting providers from entering the program, delivering the services, continuing to deliver the services, and ultimately pushes providers to serve other populations that reimburse at higher rates for the same or similar services.
- There is currently an eight to twelve week waiting period for women who are placed on the waitlist for Special Connections services. This equates to an entire trimester for pregnant women who are seeking substance use treatment. The long wait for treatment creates additional risks to both the woman and her child.
- The state is paying for the consequences of not treating these women and their families through the child welfare system and the criminal justice system, as well as other healthcare costs that arise from not receiving the appropriate prenatal care.
- OBH is working to improve data collection efforts, including the implementation of the COMPASS project.[43]

The MPRRAC and stakeholders noted their support of the recommendations below.

Department Recommendations

1. Further align with and support Office of Behavioral Health (OBH) efforts to increase data availability, consistency, and validity.
2. Further evaluate whether initiating a rate setting project would be beneficial.[44]
3. Conduct a provider survey to augment data currently available and to identify areas for impacting program improvement.

Dialysis and End-Stage Renal Disease (ESRD) Treatment Services

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for dialysis and ESRD treatment services were 83.26% of the benchmark. Rate benchmark comparisons varied; payments varied between 73.46% and 90.02%

[43] The Department will follow-up with OBH periodically to ensure data is shared as available, as this information is necessary to further inform Department initiatives for Special Connections Program services.
[44] See the Establishing Provider Payment Rates and Methodologies: A Short Primer for more information regarding the difference between the Department rate setting and rate review processes.

of the benchmark.[45] Analyses suggest dialysis and ESRD treatment services payments were sufficient to allow for member access and provider retention.

Considerations

The Department covers ESRD treatment for the first 90 days after beginning facility-based dialysis treatment, after which most Medicaid members with ESRD become eligible for Medicare.[46] Medicaid members with ESRD who receive an in-home dialysis training become eligible for Medicare on the day of that training or the first day of in-home treatment, whichever is first (i.e. they do not have to wait 90 days).

The Department is aware that in-home dialysis care is preferable for certain members. Several clinical and academic studies have highlighted the health, social, and economic benefits of in-home dialysis.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) are two types of in-home dialysis that require daily treatments. Medicare accounts for each day (seven days per week) a patient received CAPD or CCPD and then applies a unit conversion calculation to arrive at the number of days (three) per week that the patient would have visited a clinic, had they received hemodialysis in a facility setting. Medicare then reimburses providers an equivalent rate. Colorado Medicaid reimburses the same facility rate for each day a patient receives CAPD or CCPD as it does for each visit to a dialysis facility. The result is that Medicaid currently pays the facility rate for four extra days per week of CAPD or CCPD treatment than for patients receiving hemodialysis facility treatments, compared to Medicare.

The MPRRAC and stakeholders noted their support of the recommendations below.

Department Recommendations

1. Evaluate potential reimbursement method changes for in-home Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis services, which would align more closely with the Medicare payment methodology.[47]
2. Evaluate factors that impact utilization of in-home dialysis, including Medicare enrollment, and methods to improve access to in-home dialysis options where appropriate.

[45] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; detailed rate comparison results are contained in Appendix B of the report; visual representations of variations in the rate benchmark comparisons and access to care analyses are contained in Appendix C of the report.
[46] ESRD patients are eligible for Medicare the first day of the fourth month of facility-based treatment.
[47] This recommendation aligns with the Governor's November 1, 2019 executive budget request R-10, "Provider Rate Adjustments."

Durable Medical Equipment (DME)

Summary of Findings

The results of the 2019 Medicaid Provider Rate Review Analysis Report revealed that the Department's payments for DME not subject to Upper Payment Limits (UPL)[48] were 104.84% of the benchmark. Rate benchmark comparisons varied widely by individual service; payments varied between 3.9% and 1,478% of the benchmark.[49] Analyses suggest DME payments were sufficient to allow for member access and provider retention. Current data suggest that UPL DME rates are sufficient for provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

Considerations

DME rates subject to the UPL cannot be raised above the UPL. Data analyses conducted by the Department did not indicate that access was impacted by UPL implementation. However, the Department does not yet have the 18 months of claims run-out data necessary to observe the full impact of the change since UPL rates were implemented in January 2018. The Department provided additional reimbursement to certain DME providers through April 2018.

The MPRRAC and stakeholders noted their support of the first two recommendations below, but also suggested the following recommendation:

- The Department will consider reimbursing for a service component for the use of DME, in addition to current reimbursement for the equipment itself.

Department Recommendations

1. Evaluate individual services not subject to the UPL that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.[50,51]
2. Continue access to care evaluation of DME services subject to the UPL and work with state and federal partners to identify solutions to impacted services. [52]

[48] Payment rates for DME subject to UPL were 100% of the benchmark (Medicare).
[49] Information regarding variations in rate benchmark comparisons is contained in the 2019 Medicaid Provider Rate Review Analysis Report; detailed rate comparison results are contained in Appendix B of the report; visual representations of variations in the rate benchmark comparisons and access to care analyses are contained in Appendix C of the report.
[50] This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.
[51] This recommendation aligns with the Governor's November 1, 2019 executive budget request R-10, "Provider Rate Adjustments."
[52] The Department will continue to analyze claims data up through 22 months post-UPL implementation, to determine if provider retention and service utilization patterns changed and to quantify any change.

3. Evaluate the benefit of DME service component reimbursement.[53,54]

[53] This component would be in addition to current reimbursement for the equipment itself.
[54] This recommendation was added in response to MPRRAC and stakeholder feedback.