COLORADO
Department of Health Care Policy & Financing

Establishing Provider Payment Rates and Methodologies: A Short Primer

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The Colorado Department of Health Care Policy and Financing (Department), as part of the executive branch of the State, and the Colorado General Assembly, as part of the legislative branch, set provider payment rates for services rendered through the Colorado Medical Assistance Program (Colorado Medicaid). This primer introduces the concept of rate setting as it pertains to Colorado Medicaid, including: when and why rates are set, where to locate a set rate and considerations that impact how rates are set.

Rate Setting

Rate setting is the process of determining how much the state will pay for a provider's service or activity. Rate setting is necessary for the effective functioning of the Colorado Medicaid program.

The Department may adjust rates:

- as required by applicable state and federal laws, regulations, and actuarial standards of practice;
- as required by the Legislature to maintain the state budget;
- when components of a rate or payment methodology change; and
- when new medical technologies, services, and provider types require development of a payment methodology or rate.

Note: The Department's rate setting process is ongoing and separate from the rate review process established by Senate Bill 15-228. In the rate review process, the Department examines certain categories of services on a five-year cycle and evaluates whether established rates are sufficient to allow for provider retention, client access, and the reimbursement of high-value services.

Fee Schedule Rates

State Medicaid agencies commonly pay providers fee-for-service (FFS), through a managed care (capitation) arrangement, or by using value-based payment methods. The Department pays most providers a fixed, pre-determined rate for each service provided (e.g. a lab test, a wellness exam or a physical therapy session) for a specific unit of time (e.g., per visit, per 15-minutes or per day).

The Colorado Medicaid Provider Rate and Fee Schedule webpage contains links to provider payment rate and fee schedules. Instructions on how to read a rate or fee schedule are located on the Department website.

Rate Setting Methodologies

In general, within federal regulations, states have broad flexibility to establish provider payment rates and methodologies.

Examples of methods used to set provider payment rates include, but are not limited to: [1]

- Determining a rate based on the average market price of all components necessary to provide a service. Components may include direct and indirect care, administration, facility overhead, and capital overhead.
- Using a cost-based rate methodology. This may involve collecting annual cost reports from facilities, hiring an auditor to review reported costs, adjusting reported costs to ensure alignment with state and federal regulations, and paying a final cost-based rate on a retrospective or prospective cost period.
- Tying a rate to a national benchmark rate, such as a rate found on the Medicare Fee Schedule or a usual and customary rate paid by private parties.
- Basing a rate on a grouper methodology. This may involve setting a single rate for alike services (e.g. services with similar resource and staffing requirements).

Note: Comparing Colorado Medicaid provider payment rates with the rates of other public and private payers - for the purposes of developing, reviewing and/or periodically re-setting a rate - is challenging.

National and state payers often use different rate setting methodologies. For example, other payers may set rates: prospectively or retrospectively; based on a fee schedule or relative value scale; per day, per visit, or per encounter; per episode or as part of a bundled payment; at a capitated amount; or tied to supplemental or incentive payments.

In certain circumstances, the Department makes supplemental payments to providers above the established provider payment base-rate. Supplemental payments may not exceed federally established upper payment limits.[2]

Considerations When Setting a Rate or Restructuring a Payment Methodology

Federal Authority

Section 1902(a)(30)(A) of the Social Security Act requires state Medicaid agencies to "assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available." In accordance with associated regulations, for each proposed reduction in a provider payment rate or restructuring of a provider payment methodology, the Department must also:

- submit a review that demonstrates sufficient access to the service;
- further monitor access to said service for a period of at least three years after the effective date of the State Plan Amendment that authorizes the payment reduction or restructuring.

The above requires significant staff resource; federal approval takes time and is not guaranteed.

[1] The examples that follow are not indicative of how all Colorado Medicaid rates are, will be, or should be set. They are illustrative examples provided here to introduce basic concepts. State Medicaid programs, including Colorado, are increasingly moving to sophisticated payment strategies that emphasize value-based payment. For more information on payment approaches visit: https://www.macpac.gov/wp-content/uploads/2015/03/March-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf

[2] Federal regulations establish upper payment limits for the following types of services: inpatient hospital services, outpatient hospital services, nursing facilities, clinics, physician services (for states that reimburse targeted physician supplemental payments), intermediate care facilities for the developmentally disabled and private residential treatment facilities and institutes for mental disease. For more information, visit: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/accountability-guidance.html

State Spending and Statutory Authority

In most states, the executive branch initiates the main appropriation bill for the ongoing operations of state government. Colorado, however, has a strong legislative budget process. The Governor initially submits a complete, balanced budget for the operations of state government to the Legislature annually on November 1st, which includes Department requested changes to provider payment rates. However, the General Assembly's permanent fiscal and budget review committee, the Joint Budget Committee (JBC), sponsors the annual appropriations bill (called the "Long Bill").[3]

The General Assembly is statutorily required to balance the state budget. During February and March, the JBC makes initial funding decisions for the upcoming fiscal year; the broader General Assembly then approves them. The Long Bill provides spending authority that reflects the decisions made by the General Assembly throughout the budget process.

Any changes to rates or provider payment methodologies must also be compatible with existing state statutes and Colorado Medical Assistance Program rule, located in Volume 8 of the Colorado Code of Regulations.[4] The governor-appointed Medical Services Board is responsible for adopting rules that govern the Department's programs.

Staff Resource

Implementation and periodic recalculation of a rate requires staff resource.

- For example, if the Department calculates a rate for a particular service or product as a percent of the average market price (AMP) plus a flat fee, staff must research the AMP prior to setting the rate. Staff must also assess both the AMP and the flat fee over time, in order to modify both based on market trends and budget constraints.

System Changes

Providers submit FFS claims to the Medicaid Management Information System (MMIS) or the Pharmacy Benefits Management System. Certain changes to provider payment methodologies necessitate changes within these systems.

- For example, if the Department were to adopt a methodology that requires all drugs on a single claim paid at a percentage of AMP, plus a flat fee, the Department would need to reprogram the MMIS to price the claim accordingly.

System changes require staff resource and time to complete and may incur costs.

Availability of Information

The Department is able to create or adjust a provider payment methodology only to the extent that necessary information exists and outside parties make that information available.[5]

- For example, to develop a rate based on costs, the Department must have access to cost reports.

External Operational Factors

The Department's ability to implement a rate change or a new provider payment methodology successfully can also depend on operational factors outside of state or federal control.

- For example, certain provider payment methodologies require complex billing structures. The ability of providers to operationalize these structures can determine the ultimate success of the new methodology.

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[3] For more information on the role of the JBC, visit: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/jbcrole.pdf

[4] To access the Colorado Code of Regulations, visit the Secretary of State website: http://www.sos.state.co.us/CCR/Welcome.do

[5] As of 2016, there is no national database of rates across all states or payers.