COLORADO
Department of Health Care Policy & Financing

Medicaid Provider Rate Review Advisory Committee (MPRRAC)

March 29, 2019 Meeting Minutes

303 East 17th Avenue, Denver, CO 80203

9:00 a.m. – 1:00 p.m.

Please find the meeting audio recording at this link.

1. Call to Order

The meeting was called to order at 9:00 a.m.

2. Roll Call

MPRRAC Members (in person)

Wilson Pace (Chair), Rebecca Craig (Vice Chair), Susan Flynn, Gretchen McGinnis, Tia Sauceda, Arthur Schut

MPRRAC Members (by phone)

Bill Munson, Jeff Perkins, Tom Rose, Barbara Wilkinson-Crowder, Murray Willis, Jody Wright, Tim Dienst

3. Agenda Review

Eloiss Hulsbrink, Rate Review Stakeholder Relations Specialist, welcomed participants and outlined the meeting agenda.

4. Special Connections Program Services

Information regarding administration of program services, the Department's rate comparison methodology, stakeholder feedback the Department received, legislative impacts, and the combination of funding used to support the Special Connections program were presented. For more information, see slides 6-17 in the March MPRRAC Meeting Presentation.

MPRRAC Discussion

Committee discussion focused on the history of the Special Connections per diem rate, the 16-bed limit regulation, how members are placed into the Special Connections program (e.g., voluntary placements or required through the legal system), the wide range of individual rate ratios for Special Connections Program services, and the potential impact of the statewide residential treatment program on the Special Connections Program.

Stakeholder Comment

Nancy Vandermark from Mental Health Colorado and Daniel Darting from Signal Behavioral Health provided feedback. Nancy stated that the per diem rate of $192.10 is too low to cover treatment costs for Special Connection program members, which causes providers to accept other, higher-paying programs, thus reducing access for pregnant

women on Medicaid to the services they need. Daniel added that there is a level of complexity both technically and from a treatment perspective; there are higher clinical hours and higher level of staff credentialing necessary to serve this population. Daniel also noted that there is a high level of grant and fundraising supporting the gap between the Special Connections per diem rate and the actual cost of treatment.

The committee engaged in conversation around who else pays for patients in residential beds in addiction treatment facilities besides Medicaid for Special Connections members and who the other patients are, if not Special Connections members, that fill these same 56 beds.

Nancy stated that Child Welfare is the largest payor for services, and the Office of Behavioral Health (OBH) also helps subsidize these costs for members. David stated that some patients are not eligible for Medicaid due to their income status; however, OBH has a higher income limit for services. Empty beds are seen as a problem in terms of sustainability for providers operating residential programs; due to the complexity of a lot of the individuals placed in these programs, and the cases that may be involved in their placement, the providers are often in a position where they have to take the next available patient that they can get into a bed, because they depend on the reimbursement for program sustainability. However, some of these patients are not Special Connections members, and sometimes not even women without children. Providers feel that it is better than having no patient in that bed. David also stated that the length of stay is a factor, as well, that increases the complexity of managing the overall number of patients in the program.

Further conversation between stakeholders, the committee, and the Department focused on the levels of residential care covered by the program, the historical rates data for services provided in the program, program outcomes, and the availability of waitlist data.

5. Dialysis and End-Stage Renal Disease (ESRD)

The utilization data, rate comparison results, and access to care analysis were presented. For more information see slides 28-52 in the March MPRRAC Meeting Presentation.

Committee Discussion

Committee discussion focused on the low utilization of dialysis professional codes compared to facility codes.

Stakeholder Feedback

The Department did not receive feedback from stakeholders regarding dialysis and ESRD services during the March MPRRAC meeting.

6. Meeting Minutes Approval

January and February Meeting Minutes were approved; Murray Willis commented that he was present at the February MPRRAC meeting and requested to be added to the Roll Call prior to releasing the final minutes.

7. Fee-for-Service (FFS) Behavioral Health Services

The utilization data, rate comparison results, and access to care analysis were presented. For more information, see slides 58-73 in the March MPRRAC Meeting Presentation.

Committee Discussion

The committee discussion focused on how the procedure code data was identified for FFS behavioral health services and which provider types the data represents.

Stakeholder Comment

The Department did not receive feedback from stakeholders regarding FFS Behavioral Health Services during the March MPRRAC meeting.

8. Residential Child Care Facilities (RCCFs)

The utilization data, rate comparison results, and access to care analysis were presented. For more information, see slides 77-92 in the March MPRRAC Meeting Presentation.

Committee Discussion

Committee discussion focused on why utilizers have decreased over time and questions regarding how providers were counted (i.e. by facility or individual providers). The Department shared that there has been a tremendous amount of work in the child welfare space to keep children in home and community-based settings, which could account for some of the decrease in utilization.

Stakeholder Comment

Jenise May, from the Colorado Association of Family and Children's Agencies (CAFCA), emphasized the reduction in RCCF providers in the state, citing the lack of rate increases over time, especially in terms of inflation. Jenise also mentioned the need for specialty psychiatric providers required to care for children in RCCF settings, which are not reimbursed based on complexity.

Karen Yarberry, from Jefferson Hills, confirmed that a lot of providers have left the area and stated that others have had to restructure their business models. She concluded that this has caused an access issue due to RCCFs' ability to stay in business and offer treatment.

Dave Eisner, from CAFCA, stated that their waitlist increased from about two weeks to two months. He cited lower reimbursement for psychiatrists compared to those working in the private sector.

Committee members and stakeholders discussed how RCCF costs include staffing and other costs that are not covered by Medicaid.

9. Psychiatric Residential Treatment Facilities (PRTFs)

The Department's rate comparison methodology for Psychiatric Residential Treatment Facilities services and more details about the PRTF benefit were presented. For more information, see slides 96-100 in the March MPRRAC Meeting Presentation.

Committee Discussion

Committee discussion focused on how payments are structured for PRTFs, including how counties pay for room and board. There was also discussion regarding the complexity of member needs in PRTF settings.

Stakeholder Comments

Cedar Springs Hospital, a PRTF provider, stated that the per diem rate for PRTF services barely covers daily operational costs.

10. Ambulatory Surgical Centers (ASCs)

The utilization data, rate comparison results, and access to care analysis were presented. For more information, see slides 105-127 in the March MPRRAC Meeting Presentation.

Committee Discussion

Committee discussion focused on the differences between Medicare and Colorado Medicaid's reimbursement methodology for ASCs, as well as the amount of codes that are reimbursed by Medicare compared to the amount of codes reimbursed by Colorado Medicaid. Discussion included migrating services from hospital settings to ASC settings and the Colorado Medicaid grouper methodology.

Stakeholder Comments

A stakeholder from the Colorado ASC Association stated that he believes expanding the list of codes reimbursed in ASCs by Colorado Medicaid will help increase access to care. He also stated that the Multiple Procedure Discounting done by Medicare more accurately incorporates the costs of materials used in a procedure, which, if implemented by Colorado Medicaid, could lead to increased ASC utilization and thus significant cost savings over time.

11. Durable Medical Equipment (DME)

The utilization data, rate comparison results, and access to care analysis were presented. For more information, see slides 131-152 in the March MPRRAC Meeting Presentation.

Committee Discussion

Committee discussion focused on the impact of the Upper Payment Limit (UPL) implementation and the difficulties delivering DME, because providers are only reimbursed for the equipment itself, not distance traveled to deliver the equipment.

Stakeholder Comments

The Department did not receive feedback from stakeholders regarding DME during the March MPRRAC meeting.

12. Next Steps

Next steps, including report due dates and future meeting dates, were reviewed. For more information, see slide 157 in the March MPRRAC Meeting Presentation.

13. Adjourn

The meeting was adjourned at 12:50 p.m.

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