

# 2016 Medicaid Provider Rate Review Recommendation Report

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**November 1, 2016**

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



**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 contains the Department’s recommendations for services under review this year:

|                                   |                                              |
|-----------------------------------|----------------------------------------------|
| Laboratory and pathology services | Non-emergent medical transportation services |
| Home health services              | Emergency medical transportation services    |
| Private duty nursing services     | Physician-administered drugs                 |

The Department’s recommendations were developed after working with: the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and stakeholders to identify strategies to address the findings of the [2016 Medicaid Provider Rate Review Analysis Report](#) (2016 Analysis Report); and 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 for consideration in formulating the budget for the State Department.

The MPRRAC developed general impressions and recommendations for the six services under review after reviewing the 2016 Analysis Report and after collaborative discussion between committee members, stakeholders, and the Department over nine Department-led and MPRRAC-led presentations. MPRRAC recommendations, as well as summaries of all meeting discussions, can be accessed via the [MPRRAC website](#).

This report contains: a summary of discussions between the MPRRAC, stakeholders, and the Department; the MPRRAC’s recommendations; the Department’s considerations in developing Department recommendations; a fiscal analysis of MPRRAC recommendations; and the Department’s recommendations regarding changes to rates for services under review.

The Department:

- does not currently propose changes to laboratory and pathology service rates; as a part of the Department’s rate setting process, the Department will reevaluate laboratory service rates after Medicare publishes new rates in 2017;
- does not recommend changes to home health service and private duty nursing service rates;



- does not currently propose changes to non-emergent medical transportation service and emergency medical transportation service rates; in 2017, the Department plans to evaluate better claims data, which will be available via the new non-emergent medical transportation broker, and investigate the MPRRAC's recommendations; and
- does recommend changes to physician-administered drug rates; the Department recommends updating the pricing for physician-administered drugs on a periodic basis consistent with pricing for other drugs.

The Department makes these recommendations understanding that the services under review this year are only a part of a larger set of services. Services reviewed this year encompass 2,314 medical procedure codes; an additional 13,770 codes will be analyzed in the remaining four years of the five-year rate review schedule.

Members of the public are invited to attend MPRRAC meetings, provide input on provider rates, and engage in the rate review process. The five-year rate review schedule, MPRRAC meeting schedules, past MPRRAC meeting materials, and more can be found on the Department's [MPRRAC webpage](#).



## II. Introduction

### Background

In 2015, the General Assembly adopted Senate Bill 15-228 “Medicaid Provider Rate Review”, an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with CRS 25.5-4-401.5, the Department established a rate review process that involves four components:

- assess and, if needed, revise a five-year schedule of rates under review;<sup>1</sup>
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review and present the findings in a report published the first of every May;
- develop strategies for responding to the analysis 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. The MPRRAC recommends changes to the five-year schedule, provides input on published reports, and conducts public meetings to allow stakeholders the opportunity to participate in the process.

On May 2, 2016, in accordance with CRS 25.5-4-401.5, the Department published the [2016 Medicaid Provider Rate Review Analysis Report](#) (2016 Analysis Report) for the six services under review in year one of the rate review process.

The six services are:

- laboratory and pathology (laboratory) services;
- home health services;
- private duty nursing (PDN) services;
- non-emergent medical transportation (NEMT) services;
- emergency medical transportation (EMT) services; and
- physician-administered drugs.

The 2016 Analysis Report contained analyses of available utilization, access, quality, and rate comparison data, to help assess whether payments were sufficient to allow for

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<sup>1</sup> The Department received approval from the Joint Budget Committee to exclude certain rates from the rate review process. Rates were generally excluded when: rates are based on costs; there is an established process delineated in statute or regulation for rate updates; rates are a part of a managed care plan; or payments are unrelated to a specific service rate. For more information see the five-year schedule.



provider retention, client access, and appropriate reimbursement of high-value services. Within the 2016 Analysis Report, the Department concluded, as of July 2015, in aggregate:

- laboratory service payments were likely sufficient to allow for provider retention and client access (p. 31);
- home health and PDN service payments were likely sufficient, though other, non-fiscal factors may have impacted client access and provider retention (pp. 57-8 and p. 42, respectively);
- the Department was unable to draw reliable conclusions on the sufficiency of non-emergent medical transportation service rates to allow for provider retention and client access (p. 66);
- emergency medical transportation payments were likely sufficient to allow for provider retention and client access, however, they may not support appropriate reimbursement for high-value services (p. 80); and
- physician-administered drug payments for most physician-administered drugs were likely sufficient to allow for provider retention and client access (p. 93).

This document serves as the second report in the annual rate review process. It contains the Department's recommendations for services under review in year one. The Department's recommendations were developed after working with the MPRRAC and stakeholders to identify strategies to address the findings of the 2016 Analysis Report and 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 for consideration in formulating the budget for the State Department.

### **Rate Review Process in Context**

The rate review process, and any resulting Department recommendations for changes to rates, is one of many Department efforts that monitors and impacts service delivery, to achieve the Department's mission of improving health care access and outcomes for the people we serve while being sound stewards of financial resources. Levers, other than changes to rates, that can impact service delivery, include:

- the Department's efforts to evaluate and ensure access to services in accordance with 42 CFR § 447.203,<sup>2</sup> which requires the Department to analyze and report

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<sup>2</sup> In October 2015 the Centers for Medicare and Medicaid Services issued the final rule "[Methods for Assuring Access to Covered Medicaid Services](#)" (CMS-2328-FC), establishing a process for the ongoing analysis and monitoring of Medicaid member access to medical assistance, and specifically: primary care services; specialty care services; fee-for-service behavioral health services; obstetric services; and home health services.



access to care and rate comparison data for five core, required Medicaid services at least once every three years, and for each State Plan Amendment proposing to reduce or restructure rates;

- current and future efforts of the Accountable Care Collaborative, which provides a person-centered approach to coordinated care and connects members to medical and community resources, with a goal of achieving better health outcomes at lower costs; and
- ongoing benefit policy development and revision processes, such as Benefit Collaboratives and general rule making involving the Medical Services Board, in which access, quality, and service utilization are considered.

Additional, service-specific efforts outside of the rate review process are listed throughout this report.

### **General MPRRAC Guidance**

In year one of the rate review process, the Department led seven presentations on utilization, access, and quality data analyses. High-level presentations took place during MPRRAC meetings and in-depth presentations occurred during Rate Review Information Sharing Sessions (RRISS). After the publication of the 2016 Analysis Report, MPRRAC members formed four workgroups to discuss strategies to address the findings of the report. During a day-long MPRRAC meeting, guiding principles were developed and MPRRAC workgroups led service-specific discussions with committee members, stakeholders, and the Department. These discussions informed the development of MPRRAC recommendations. The Department evaluated the MPRRAC's recommendations, as outlined in this report, and used those recommendations in formulating Department recommendations. The MPRRAC also indicated they would like to work with the Department to prospectively identify ways that changes to rates and methodologies will be evaluated, including potential measures and time frames for evaluation.

### **MPRRAC Rate Setting Suggestions**

During committee and stakeholder discussions, two themes repeatedly emerged, which relate to both the rate review process and the Department's rate setting process. The MPRRAC suggested:

- the Department should investigate setting different rates for urban and rural areas; and



- the Department should attempt to bring its rates to parity with other entities' rates (e.g., Medicare, surrounding state Medicaid programs).

Both suggestions are further outlined below:

### ***Geographic Differences***

Committee members and stakeholders stated that establishing higher provider reimbursement rates in rural areas, compared to urban areas, could offset high overhead costs associated with the provision of certain services within these areas and increased travel distances.

The Department continues to explore the feasibility of geographic adjustment in various rate methodologies. In addition, new federal access to care regulations, mentioned above, require the Department to monitor access to five key services throughout the state. As a part of these new regulations, the Centers for Medicare & Medicaid Services (CMS) has reaffirmed a willingness to discuss differential payment rates to rural providers, if states determine a rate differential is the best tool to ensure access in rural areas. As the Department conducts access analyses during the rate review process, and similar analyses for compliance with federal regulations, the Department will aim to understand what data might support the need for increased rates in rural areas and will work with our federal partners to develop feasible solutions.

### ***Comparator Rates***

There are two primary ways the Department may utilize another entity's rates:

- to verify the validity of a Department-calculated rate; or
- as the basis for a Department rate.

In the first instance, the Department develops a rate through its normal rate setting process, which includes determining fixed cost and variable cost inputs, and then compares the rate to those of other entities. In making such a comparison, the Department seeks information on service descriptions, client eligibility definitions, unit information, and delivery systems. If the Department-calculated rate is considerably above or below the rates of other entities, and the difference cannot be explained by the abovementioned comparison, the Department reevaluates if all appropriate inputs were accounted for in the original rate calculation. The Department may also reach out to stakeholders to identify any excluded inputs, or



inputs that were not originally priced correctly. The Department may then make changes to that rate setting method.

If the Department decides to use another entity's rate as the basis for a Department rate, there are multiple considerations the Department must investigate first. In addition to conducting the comparison mentioned above, the Department investigates if the other entity's rate is widely used by other payers and if the rate setting process is transparent and informed by robust data analysis. This level of scrutiny is necessary to ensure rates are appropriate for the services provided and to understand how rates would affect the Department's budget over time. If, for example, the Department were to tie its rate to another entity's rate, which increased drastically from one year to another, it would require additional appropriations from the General Assembly to account for the corresponding change. The Department may propose to use another entity's rates as the basis for Department rates only if the above criteria is met.

### **Guiding Principles**

Committee members and the Department share the goal of using the rate review process to critically analyze rates and develop appropriate recommendations. During the rate review process, the MPRRAC identified a series of overarching guiding principles to guide their evaluation of Department-presented information and their development of recommendations. When considering changes to rates and service delivery, the Department will use these guiding principles to inform its final recommendation development. The MPRRAC's guiding principles are:

- "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; and

Rates and methodologies should attempt to cover the direct costs of goods and supplies for providers. The MPRRAC's unaltered recommendations and guiding principles are presented in this report and informed the Department's recommendations within this report.



## Format of Report

Sections III through VIII of this report include MPRRAC and Department recommendations pertaining to each of the six services under review. Information in each section is presented in the following format:

- Service Information – includes a brief service description and a summary of the findings of the 2016 Analysis Report.
- Discussion of Service and Analysis – summarizes discussions between committee members, stakeholders, and the Department and includes high-level concerns identified by committee members and stakeholders.
- MPRRAC Recommendations – states the MPRRAC’s general impression and recommendations.
- Department Considerations – outlines Department considerations and summarizes any efforts outside of the rate review process that may impact service delivery.
- Fiscal Analysis – when MPRRAC recommendations are specific enough to warrant an analysis of the expected fiscal impact, an impact analysis is provided; when MPRRAC recommendations call for an investigation, any needed additional resources are specified. This section also notes if an MPRRAC recommendation would require additional appropriations from the General Assembly.
- Department Recommendation – states the Department’s recommendation and details any additional steps the Department plans to complete.



### III. Laboratory Services

Laboratory services involve the collection and analysis of bodily fluids or specimens for screening and treatment of diseases and disorders. Laboratory services are a mandatory State Plan benefit offered to all Health First Colorado (Colorado's Medicaid Program) clients. The 2016 Analysis Report contains a detailed service description (p. 18).

In the 2016 Analysis Report, the Department concluded that laboratory service payments were sufficient to allow for provider retention and client access. This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>3</sup>

The Department's access analysis identified areas of the state that require further research over time to understand atypical utilization trends. The Department will continue to monitor utilization and access patterns in these regions.<sup>4</sup>

#### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, Department staff, committee members, and various stakeholders discussed:<sup>5</sup>

- an Office of the Inspector General (OIG) report, "Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings", which indicates Medicare payments for laboratory tests may be higher than other insurers,<sup>6</sup> and
- CMS's Clinical Laboratory Fee Schedule final rule, "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System", which would require laboratories to report the rates they received from other payers and then base Medicare rates on a methodology that incorporates other payers' average rates.<sup>7</sup>

Committee members indicated their belief that current reimbursements for laboratory services may, in some cases, be higher than necessary. They suggested that the new

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<sup>3</sup> The laboratory services benchmark was established using [Medicare's Clinical Laboratory Fee Schedule](#), [Medicare's Average Sales Price Drug Price File](#), [Medicare's Physician Fee Schedule](#), and Medicaid fee schedules from [Alabama](#), [Kentucky](#), [Mississippi](#), [Texas](#), [Washington](#), and [West Virginia](#).

<sup>4</sup> Cheyenne, Hinsdale, Jackson, and Ouray Counties require further research (2016 Analysis Report, pp. 25-6).

<sup>5</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [December 4, 2015](#) and [February 19, 2016](#).

<sup>6</sup> "Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings", OEI-07-11-00010, June 2013.

<sup>7</sup> "[Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System](#)", June 2016.



Medicare rates, once published, would be more appropriate rates to which the Department could tie its rates.

### **MPRRAC Recommendations**

The MPRRAC's general impression is that the Department may be overpaying on laboratory service rates.

The MPRRAC recommends:

1. Moving forward, the Department should attempt to gather additional data on Medicare and commercial payments for laboratory services to make sure that Medicaid payments are appropriate. The MPRRAC is interested in, and recommends the Department investigate, Medicare's restructuring of rates, when they become available, as described in the CMS Clinical Laboratory Fee Schedule (CLFS) final rule entitled "Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System"; and
2. The Department continue its annual rate setting process, particularly for laboratory services that are not reimbursed by Medicare.

### **Department Considerations**

Results from the 2016 Analysis Report and the above mentioned OIG report lend support for the MPRRAC's impression. Results from the 2016 Analysis Report suggest that laboratory service payments at 87.96% of the benchmark were sufficient to allow for provider retention and client access to laboratory services. Additionally, based on the results of the OIG report, the Department and committee members anticipate that the CLFS final rule may lower some Medicare laboratory service rates.

### **Fiscal Analysis**

#### Laboratory Recommendations 1-2

Based on the MPRRAC's recommendations, the Department does not need additional resources at this time to gather additional information and continue the rate setting process.

### **Department Recommendation**

The Department does not currently propose a change to laboratory service rates. This is informed by the results of the 2016 Analysis Report and CMS's plan to review and update



Medicare rates. After Medicare publishes new rates in November 2017, the Department plans to reevaluate laboratory service rates. The Department believes new CMS rates will be based on transparent and robust information, which will be a valuable resource for the Department's rate setting process.

The Department will continue with its current rate setting process, in alignment with MPRRAC's second recommendation.



## IV. Home Health Services

Home health services consist of skilled nursing, certified nurse aid (CNA), physical therapy (PT), occupational therapy (OT), and speech/language pathology (SLP) services. Home health services are a mandatory State Plan benefit offered to Health First Colorado (Colorado's Medicaid Program) clients who need intermittent skilled care. Rendering providers must be employed by a class A licensed home health agency. The 2016 Analysis Report contains a detailed service description (p. 43).

In the 2016 Analysis Report, the Department concluded that home health rates, in aggregate, were sufficient to allow for provider retention and that rates supported growth in utilization of services. This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>8</sup>

The Department's access analysis identified areas of the state that require further research over time to understand atypical utilization trends. The Department will continue to monitor utilization and access patterns in these regions.<sup>9</sup>

### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, committee members and various stakeholders offered experiential feedback. They indicated that home health agencies have difficulty recruiting and retaining staff and attributed this difficulty, in part, to competition with hospitals that offer better wages and benefit packages. They suggested that increased rates would aid recruiting and ease retention issues.<sup>10</sup>

Meeting participants also: asked to see more quality of care data for home health services; noted that transportation costs are an issue for home health providers; and suggested that visit-based reimbursements might not appropriately reimburse for all of the services provided.

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<sup>8</sup> The home health services benchmark was established using Medicaid fee schedules from [Idaho](#), [Illinois](#), [Louisiana](#), [North Carolina](#), [Nebraska](#), and [Ohio](#).

<sup>9</sup> For long-term home health services, Health Statistics Regions (region) 11 (Jackson, Moffat, Rio Blanco, and Routt Counties) and 12 (Eagle, Garfield, Grand, Pitkin, and Summit Counties) require further research (2016 Analysis Report, pp. 48-51). For acute home health services, Cheyenne, Kit Carson, and Lincoln Counties in region 5 and Alamosa, Costilla, Mineral, Rio Grande, and Saguache Counties in region 8 require further research (2016 Analysis Report, pp. 51-4). More information on Health Statistics Regions can be found on the [Colorado Department of Public Health and Environment \(CDPHE\) website](#).

<sup>10</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [February 19, 2016](#) and [June 17, 2016](#).



## MPRRAC Recommendations

The MPRRAC's general impression is that home health reimbursement is below market, therefore the Department should consider increasing rates.

The MPRRAC recommends:

1. The Department increase rates towards 90% of Medicare's Low-Utilization Payment Adjustment (LUPA) rate over three years, then maintain 90% of the LUPA rate in subsequent years; and
2. The Department investigate, as an alternative to the current visit-based payment methodology, unit-based payment methodologies.

## Department Considerations

The Department does not share the MPRRAC's impression that home health reimbursement is below market. Results from the 2016 Analysis Report indicate that home health service payments are between 72.49% and 197.11% of other state Medicaid rates. The number of providers appeared sufficient to accommodate increases in utilization, which would not be likely had reimbursement been insufficient.

In addition, the Department's analysis is that Medicare's LUPA rate is not an appropriate comparator rate.<sup>11</sup> Reasons include, but are not limited to, differences in:

- Client eligibility – Medicare clients must be confined to the home to receive home health services, Health First Colorado clients are not.<sup>12</sup>
- Utilizer characteristics – Medicare provides services for the elderly, while Health First Colorado provides home health services to other populations, including children and adults, who have different diagnoses and health care needs.<sup>13</sup>

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<sup>11</sup> In addition to the reasons that follow, The [Medicaid Payment Advisory Commission's \(MedPAC\) response](#) to CMS's proposed rule "Calendar Year 2017 Home Health Prospective Payment System Rate Update" indicates MedPAC also believes Medicare's home health rates are too high.

<sup>12</sup> This may indicate that Medicare clients are higher acuity clients that require higher levels of, and more costly, care. This is supported by claims data; in FY 2014-15, 57% of Health First Colorado home health service utilizers were dually eligible for Medicare and Medicaid. This indicates that these Health First Colorado clients, despite being Medicare eligible, did not meet criteria to access Medicare's home health benefit.

<sup>13</sup> For example, in FY 2014-15, infantile cerebral palsy was the most common principle diagnosis for Health First Colorado's long-term home health services and the second most common principle diagnosis for acute home health services. This is not a diagnosis that would typically be covered by Medicare home health services.



- Unit designations - Health First Colorado has some tiered payments based on visit type, Medicare does not.<sup>14</sup>

There is evidence of a statewide nursing shortage in Colorado, which impacts providers and clients of all payer-types.<sup>15</sup> While the Department can provide data and expertise to support efforts to address the shortage, the Department does not believe that a standalone, Medicaid-specific rate increase will address the statewide nursing shortage.

If home health rates were increased, it is unclear to what degree the increase would alleviate concerns regarding home health employee recruitment and retention. Differences between employment in facility settings and home settings extend beyond wages, to include the types of services being provided, employee travel, and scheduling differences. Furthermore, because the Department sets rates that are paid to home health agencies, which in turn determine the wages paid to their employees, it would be difficult for the Department to evaluate the direct impact of a rate change on home health employee wages.

Outside of the rate review process, the Department is already taking steps, specific to home health services, to improve service delivery. These efforts include implementing new federal regulations which:

- clarify that Health First Colorado home health services and items are not limited to home settings; and
- require changes to the coverage of medical supplies, equipment and appliances under the home health benefit.

## **Fiscal Analysis**

### Home Health Recommendation 1

Though the Department's evaluation is that Medicare's LUPA rate is not a comparable rate, the MPRRAC's recommendation provided enough specificity to warrant a fiscal analysis, which the Department has provided below. If the Department were to increase reimbursement for home health services to 90% of LUPA rates over the course of three years, the expected expenditure increase would be:

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<sup>14</sup> For example, Health First Colorado has three tiered rates for RN visits, based on initial visits, extended visits, and closing visits.

<sup>15</sup> More information can be found in the U.S. Department of Health and Human Services Health Resources and Services Administration's "[The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025](#)".



| <b>Estimated Impact of Increasing Home Health Rates to 90% of Medicare's Low Utilization Payment Adjustment (LUPA) Rate by Fund Split</b> |                    |                     |                   |                      |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------|-------------------|----------------------|
| <b>Item</b>                                                                                                                               | <b>Total Funds</b> | <b>General Fund</b> | <b>Cash Funds</b> | <b>Federal Funds</b> |
| FY 2017-18 Annual Impact                                                                                                                  | \$26,691,430       | \$12,785,520        | \$185,070         | \$13,720,840         |
| FY 2018-19 Annual Impact                                                                                                                  | \$64,605,748       | \$30,947,214        | \$465,483         | \$33,193,051         |
| FY 2019-20 Annual Impact                                                                                                                  | \$113,751,807      | \$54,488,983        | \$850,920         | \$58,411,904         |

If the Department were directed to gather information from home health agencies regarding employee wages, this would require additional staff and potentially contracting resources.

### Home Health Recommendation 2

Currently, the Department reimburses for most home health services on a per visit basis; each visit can last up to 2.5 hours. This is considered a visit-based payment, and differs from unit-based payment. Unit-based payment, in which one unit is a specific amount of time, typically reimburses for multiple units within one visit (e.g. a one hour visit could consist of four 15-minute units). Currently, providers are not required to report, in claims data, the exact amount of time spent rendering the service. As such, the Department cannot conduct a fiscal analysis of this recommendation at this time.

### **Department Recommendation**

The Department does not recommend a change to home health service rates. This recommendation is based on the results of the 2016 Analysis Report. The Department does not believe that Medicare's LUPA rate is comparable and therefore does not recommend increasing home health rates to 90% of Medicare's LUPA rate.

While the Department does not recommend changing current rates, the Department plans to investigate what a switch from visit-based payments to unit-based payments would entail.

The Department plans to investigate:

- other state Medicaid home health programs with unit-based payments;
- if any state Medicaid home health programs changed from visit-based to unit-based payments and if they observed changes in provider retention and client utilization; and



- the systematic and operational changes such a switch might require.

## V. Private Duty Nursing Services

PDN services provide one-to-one nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). PDN services are an optional State Plan benefit that the Department offers to Health First Colorado (Colorado's Medicaid Program) clients who are dependent on medical technology and who need a higher level of care than is available via home health services.<sup>16</sup> Like home health services, rendering providers must be employed by a class A licensed home health agency. The 2016 Analysis Report contains a detailed service description (p. 32).

In the 2016 Analysis Report, the Department concluded that PDN rates were sufficient to allow for provider retention and that rates supported growth in service utilization. This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>17</sup>

### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, committee members and various stakeholders offered experiential feedback. They indicated that home health agencies have difficulty recruiting and retaining staff and attributed this difficulty, in part, to competition from hospitals that offer better wages and benefit packages. They suggested that increased rates would aid recruiting and ease retention issues.<sup>18</sup>

Additionally, some committee members suggested that increasing LPN rates might lead to a substitution effect (i.e., if LPN rates were increased, home health agencies could send LPNs in the stead of RNs). They further suggested increasing LPN rates for PDN services could save the Department money by decreasing the use of RNs, who are reimbursed at higher amounts.

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<sup>16</sup> A [2012 Kaiser Family Foundation report](#) indicated that only 23 state Medicaid agencies offered some form of PDN services.

<sup>17</sup> The PDN services benchmark was established using Medicaid fee schedules from [Idaho](#), [Illinois](#), [Louisiana](#), [North Carolina](#), [Nebraska](#), and [Ohio](#).

<sup>18</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [February 19, 2016](#) and [June 17, 2016](#).



## **MPRRAC Recommendations**

The MPRRAC's general impression is that, via the provision of PDN services, there may be opportunity for clients to receive services in less restrictive and less costly environments. Additionally, increasing LPN rates for PDN services could save the Department money by decreasing the use of RNs, who are reimbursed at higher amounts.

The MPRRAC recommends:

1. The Department gather more information about LPN reimbursement rates and/or wages from hospitals and long-term acute care facilities, to help investigate appropriate increases in the LPN rate for PDN services; and
2. The Department should maintain adequate RN reimbursement rates over time.

## **Department Considerations**

Results from the 2016 Analysis Report do not lend support for, or refute, the MRPRAC's impressions.<sup>19</sup> Results from the 2016 Analysis Report indicate that PDN service rates are between 111.80% and 144.70% of other state Medicaid rates, and that rates were sufficient to allow for provider retention and supported growth in utilization of PDN services.

Committee members and stakeholders had similar staffing concerns for both home health services and PDN services. As first stated in the home health services section above, it is unclear to the Department to what degree a Medicaid-specific rate increase would alleviate concerns regarding home health employee recruitment and retention, given: the statewide nursing shortage; inherent differences in facility vs. home based work settings; and the fact that the Department lacks access to home health agency employment information.

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<sup>19</sup> For example, the Department does not possess data on whether nursing facilities or inpatient hospital facilities currently keep waitlists for clients who wish to transition to PDN services.



## **Fiscal Analysis**

### Private Duty Nursing Recommendation 1

Based on the MPRRAC's recommendation, the Department does not need additional resources at this time to gather additional information.

### Private Duty Nursing Recommendation 2

The Department notes that any future increases to RN rates will require additional appropriations from the General Assembly.

## **Department Recommendation**

The Department does not recommend a change to current PDN rates. This is informed by the results of the 2016 Analysis Report.

Regarding the investigation of LPN wage information from hospitals and long-term acute care facilities (LTACs), the Department plans to:

- survey several hospitals and long-term acute care facilities, and
- reach out to other state Medicaid agencies that increased their LPN rates for PDN services, to see if their data shows evidence of an LPN and RN substitution effect.

In addition to gathering LPN wage information, the Department will also attempt to gather information pertaining to the differences in client populations, facility costs, and types of services provided within facility vs home settings. This will help the Department determine if comparing LPN wages for facility and home settings is appropriate.

The Department will continue with its current rate setting process, in alignment with MPRRAC's second recommendation.



## VI. Non-Emergent Medical Transportation Services

NEMT services are transportation to and from medically necessary services for clients who have no other means of transportation. NEMT services are a mandatory State Plan benefit offered to all Health First Colorado (Colorado's Medicaid Program) clients. NEMT delivery systems differ throughout the state. The 2016 Analysis Report contains a detailed service description and explanation of the different transportation delivery systems (p. 59). NEMT services are separate and distinct from EMT services, however, it is important to review the recommendations for both services in tandem, as changes to one aspect of transportation services has the potential to impact the other.

In the 2016 Analysis Report, the Department was unable to draw reliable conclusions on the sufficiency of NEMT rates to allow for provider retention and client access. This was due to variations in the three NEMT delivery systems, including: the amount and quality of data available for each system; and a lack of reliable and complete claims data from nine urban counties prior to November 2014. Even though the Department did not offer a conclusion regarding the sufficiency of NEMT rates, the Department was able to conduct a rate comparison analysis. Results of this analysis suggest that NEMT service payments are at 28.19% of the rate comparison benchmark. This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>20</sup>

The Department's access analysis identified areas of the state that require further research over time to understand atypical utilization trends. The Department will continue to monitor utilization and access patterns in these regions.<sup>21</sup>

### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, NEMT and EMT services were presented together. Committee member and stakeholder discussions generally focused on EMT services, though meeting participants noted that a lack of reliable NEMT utilization data makes analysis difficult. One stakeholder suggested increasing access to NEMT services, particularly in rural areas, might decrease the need for EMT services. They suggested increased rates would lead to increased NEMT service providers.<sup>22</sup>

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<sup>20</sup> The NEMT services benchmark was established using Medicaid fee schedules from [Alabama](#), [Alaska](#), [Arkansas](#), [California](#), [Connecticut](#), [Montana](#), [Nebraska](#), [New Mexico](#), [North Dakota](#), and [Wisconsin](#).

<sup>21</sup> Health Statistics Region 11 (Jackson, Moffat, Rio Blanco, and Routt Counties) requires further research (2016 Analysis Report, p. 74). More information on Health Statistics Regions can be found on [CDPHE's website](#).

<sup>22</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [June 17, 2016](#).



## MPRRAC Recommendations

The MPRRAC's general impression is that NEMT rates are significantly below surrounding state Medicaid rates.

The MPRRAC recommends:

1. The Department survey surrounding states' NEMT rates and bring Colorado Medicaid rates to parity with surrounding states.<sup>23</sup>

## Department Considerations

The Department was unable to draw reliable conclusions for NEMT services in the 2016 Analysis Report due to the amount and quality of available data. However, rate comparison results indicated that NEMT service payments are at 28.19% of other state Medicaid rates. Although this benchmark comparison did not include all surrounding states, it lends support for the MPRRAC's impression.

As outlined in the 2016 Analysis Report (p. 59), there are different NEMT delivery systems throughout Colorado, with differing organizational structures and oversight processes, which result in data and performance monitoring variation.

Outside of the rate review process, the Department is taking several steps, specific to NEMT services, to improve service delivery. These steps include:

- understanding how to reduce fragmentation in the administration of NEMT services;
- working with the Public Utilities Commission (PUC) to implement HB 16-1097, which will allow NEMT providers to be licensed by the PUC as a limited regulation carrier. This new permit should lead to an increase in providers because it can be more easily obtained;<sup>24</sup> and
- implementing recommendations outlined in the Department's response to the [FY 2015-16 Legislative Request for Information #5](#). For example, the Department is:
  - engaging key stakeholders to collaborate on NEMT reform;
  - working more closely with other Colorado State agencies where their policy and planning overlaps with the Department, including the Colorado Department of Regulatory Agencies, the Colorado Department of Transportation, and the Colorado Department of Public Health and Environment; and

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<sup>23</sup> Surrounding states, suggested by the MPRRAC to survey, included: Arizona, Kansas, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Utah, and Wyoming.

<sup>24</sup> This new permit still requires regular vehicle inspections, driver background checks, and sufficient insurance.



- researching possible future public/private sector partnership solutions to expand transportation options.
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## **Fiscal Analysis**

### NEMT Recommendation 1

Based on the MPRRAC's recommendation, the Department does not need additional resources at this time to survey surrounding states. The Department notes that any future increases to NEMT rates will require additional appropriations from the General Assembly.

## **Department Recommendation**

The Department does not currently propose a change to NEMT service rates. The Department is in the process of identifying ways to capture consistent NEMT claims data. Complete and accurate claims data might inform different Department recommendations in the future. Within the EMT service section of this report, the Department provides an estimate of the costs associated with reimbursing both NEMT and EMT services to 100% of the 2016 Analysis Report benchmark.

In an effort to gather more accurate and complete NEMT claims data, the Department plans to:

- continue to research how to reduce fragmentation in the administration of NEMT services;
- look into claims adjudication information;
- study the strengths of, and any concerns with, the new nine-county state broker shared-risk contract; and
- evaluate claims data that will be available after migrating to a new Medicaid Management Information System, which should be more robust than existing claims data (e.g., there will be greater differentiation between NEMT and EMT claims).



## VII. Emergency Medical Transportation Services

EMT services include emergency ground and air transportation to and from a hospital. EMT services are a mandatory State Plan benefit offered to all Health First Colorado (Colorado's Medicaid Program) clients. The 2016 Analysis Report contains a detailed service description (p. 67). EMT services are separate and distinct from NEMT services, however, it is important to review the recommendations for both services in tandem, as changes to one aspect of transportation services has the potential to impact the other.

In the 2016 Analysis Report, the Department concluded that EMT service payments were sufficient to allow for client access and provider retention because EMT service providers cannot refuse services to clients. Despite access sufficiency, rates may not reflect appropriate reimbursement of high-value services. Analysis results indicated that EMT service payments are significantly below Medicare and other states at 30.74% of the benchmark. This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>25</sup>

The Department's access and analysis identified areas of the state that require further research over time to understand atypical utilization trends. The Department will continue to monitor utilization and access patterns in these regions.<sup>26</sup>

### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, committee members and stakeholders highlighted two broad concerns:

- EMT services must always be available, which means ambulances must be fully staffed and stocked at all times. Meeting participants said increased rates are justifiable given the costs associated with around-the-clock preparedness.
- EMT services are only reimbursed if a patient is taken to a hospital. Some committee members and stakeholders believed this incentivizes EMT providers to transport clients to the hospital, when appropriate care could be given onsite at less cost to the state. The Department does not currently reimburse for care

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<sup>25</sup> The EMT services benchmark was established using [Medicare's Ambulance Fee Schedule](#) and Medicaid fee schedules from [Alabama](#), [Alaska](#), [Arkansas](#), [California](#), [Connecticut](#), [Montana](#), [Nebraska](#), [New Mexico](#), [North Dakota](#), and [Wisconsin](#).

<sup>26</sup> Health Statistics Regions 10 (Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel Counties) and 12 (Eagle, Garfield, Grand, Pitkin, and Summit Counties) require further research (2016 Analysis Report, p. 74). More information on Health Statistics Regions can be found on [CDPHE's website](#).



provided onsite. Stakeholders suggested changing policy to reimburse for what is commonly referred to as "treat and release" care.

Meeting participants also discussed difficulties recruiting, training, and retaining staff and the need to analyze ground and air ambulance information separately in future analyses.<sup>27</sup>

## **MPRRAC Recommendations**

The MPRRAC's general impression is that EMT rates are significantly below the rates of surrounding state Medicaid programs and Medicare.

The MPRRAC recommends:

1. The Department first survey surrounding states' EMT rates and bring Colorado Medicaid rates to parity with surrounding states;
2. Over time, the Department bring EMT rates to parity with Medicare and investigate supplemental funding sources;
3. The Department look at initiating reimbursement for "treat and release" and "supplies used" codes; and
4. The Department investigate reimbursing for alternative transportation vehicles (i.e., vehicles other than ambulances).

## **Department Considerations**

Results of the 2016 Analysis Report indicated increases in EMT service providers and continued growth in utilization, but the nature of EMT service provision, coupled with service payments at 30.74% of the benchmark, indicate that EMT service payments may not support appropriate reimbursement for high-value services. Although this benchmark comparison did not include all surrounding states, the 2016 Analysis Report lends support for the MPRRAC's impression.

EMT providers must transport a client to the hospital to be reimbursed. If an EMT service provider arrives onsite and determines the client does not need to be transported to the hospital, they may: treat the client without reimbursement; or transport the client to a hospital to receive higher-cost care. Medicaid agencies have the ability to reimburse for both "treat and release" services, using existing paramedic intercept codes, and "supplies used" codes. Reimbursing EMT service providers for paramedic intercept codes could

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<sup>27</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [April 29, 2016](#) and [June 17, 2016](#).



potentially incent the delivery of needed onsite care and prevent higher-cost hospital care. The Department is open to further investigation of paramedic intercept codes. The Department currently reimburses for “supplies used” codes.

Outside of the rate review process, the Department is already working to improve EMT service delivery through efforts such as supporting the Colorado Department of Public Health and Environment (CDPHE) in the implementation of SB 16-069, a Community Paramedicine Regulation. The Department believes that this regulation, which instructs CDPHE to develop a new licensure type for community paramedicine services, may allow EMT service providers to treat a wider range of clients by providing services in the least restrictive and most cost effective environment.

## **Fiscal Analysis**

### EMT Recommendations 1-4

Based on the MPRRAC’s recommendations, the Department does not need additional resources at this time to survey and investigate. Regarding the MPRRAC’s EMT recommendations to bring rates to parity with other states and Medicare, the Department notes that any future increases to EMT service rates will require additional appropriations from the General Assembly. In the 2016 Analysis Report, the Department provided an estimate of the associated costs had it increased NEMT and EMT service rates to equal 100% of the combined NEMT and EMT benchmark. In FY 2014-15, this increase would have been approximately an additional \$74.13 million total funds and \$25.19 million General Fund (2016 Analysis Report, p. 79).

## **Department Recommendation**

The Department does not currently propose changes to EMT service rates. After the Department engages in the investigation below, the Department may offer different recommendations in the future.

The Department plans to:

- consult with surrounding state Medicaid agencies to gather information on their EMT service rates and evaluate those rates for comparability;
- reach out to our federal and state partners to understand supplemental funding sources for EMT services;
- calculate the potential budget impact of opening, and reimbursing for, paramedic intercept codes;



- examine if changes to, and clarification of, NEMT service policies lessen potentially-avoidable utilization of EMT services;
- gather more information from EMT service providers on the rate components that they feel are inadequate; and
- forecast the complete budgetary impact of rate increases to existing EMT services, including researching the direct and indirect impacts a rate change may have on the utilization of other services.



## VIII. Physician-Administered Drugs

Physician-administered drugs are medications and devices that require delivery in an office under medical supervision. Physician-administered drugs are encompassed by physician services in the State Plan and are a mandatory service offered to all Health First Colorado (Colorado's Medicaid Program) clients. The 2016 Analysis Report contains a detailed service description (p. 81).

In the 2016 Analysis Report, the Department concluded that physician-administered drug rates, in aggregate, were sufficient to allow for provider retention and client access, though the Department noted a great deal of variation exists relative to the benchmark on a drug-by-drug basis (p. 93). This conclusion was informed by both analysis of claims-based utilization data and rate benchmark comparison.<sup>28</sup>

The Department's access analysis identified areas of the state that require further research over time to understand atypical utilization trends. The Department will continue to monitor utilization and access patterns in these regions.<sup>29</sup>

### Discussion of Service and Analysis

During Rate Review Information Sharing Sessions and MPRRAC meetings, committee members and various stakeholders indicated physician offices have difficulty providing physician-administered drugs when the physician's office is reimbursed below the price paid for the drug. Meeting participants suggested that reimbursing for a drug at the cost the physician's office paid would allow providers to continue to administer the drug and might encourage other providers to begin administering the drug. Committee members and stakeholders suggested CMS's Average Sales Price (ASP) Drug Pricing File as an appropriate source for repricing many physician-administered drugs.

Multiple stakeholders advocated for moving long-acting, anti-psychotic injectables (also known as long-acting injectables, or LAIs) from the physician services benefit to the pharmacy benefit.<sup>30</sup> These stakeholders believe such a move would allow for appropriate

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<sup>28</sup> The physician-administered drug benchmark was established using [Medicare's Average Sales Price Drug Pricing File](#) and Medicaid fee schedules from [Alabama](#), [Mississippi](#), [Nebraska](#), [New Mexico](#), [North Dakota](#), and [Texas](#).

<sup>29</sup> Health Statistics Region 5 (Elbert, Lincoln, Cheyenne, and Kit Carson Counties) requires further research (2016 Analysis Report, p. 88). More information on Health Statistics Regions can be found on [CDPHE's website](#).

<sup>30</sup> Summaries of MPRRAC discussions and stakeholder comments can be found in MPRRAC meeting minutes from [December 4, 2015](#), [April 29, 2016](#), and [June 17, 2016](#).



reimbursement, because rates for drugs in the pharmacy benefit are updated more frequently.<sup>31</sup>

## **MPRRAC Recommendations**

The MPRRAC's general impression is that current Health First Colorado physician-administered drug rates are not adjusted frequently enough, therefore, there are drugs that are significantly over-reimbursed and significantly under-reimbursed when compared to current physician-administered drug prices.

The MPRRAC recommends:

1. Physician-administered drugs with an Average Sales Price (ASP) should be reimbursed using "ASP Plus" pricing and updated on a quarterly basis for all buy and bill drugs;<sup>32</sup>
2. The Department investigate carving out LAIs from the physician-administered drugs benefit and placing them into the pharmacy benefit; and
3. For physician-administered drugs that do not have a comparable Medicare rate, the Department investigate objective ways of determining cost and reimburse at a similar rate to ASP.

## **Department Considerations**

Results of the 2016 Analysis Report suggest that while payments at 100.7% of the benchmark were sufficient, in aggregate, to allow for provider retention and client access, a great deal of variation exists relative to the benchmark on a drug-by-drug basis, lending support to the MPRRAC's impression.

The Department agrees that reimbursing physician offices below the cost they paid for a drug can be problematic, particularly for providers who administer drugs as their primary function (e.g., oncologists who administer chemotherapy drugs). To address this concern, the Department is requesting funding from the General Assembly, outlined in the Department's Recommendation below.

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<sup>31</sup> Physician services and pharmacy services have different payment methodologies. Specifically, pharmacy service reimbursement rates are tied to a lesser-of payment methodology that is updated weekly. More information on pharmacy reimbursement calculations can be accessed on the [Secretary of State's website](#).

<sup>32</sup> "ASP Plus" refers to reimbursements that include both the Average Sales Price of a drug, and a certain percent of that drug's ASP to cover the administrative costs associated with administering that drug.



The Department does not recommend moving LAIs from a physician services benefit to a pharmacy benefit. Physician-administered drugs should remain in the physician services benefit to ensure proper policy for:

- Service delivery – keeping physician-administered drugs within physician services ensures the appropriate place of service. Also, moving a single drug class from one benefit to another is not in line with Department policy. It would require policy, rule, and state plan changes, with no clinical or policy justification for changing just one drug class.
- Payment methodology - under Department policy, all drugs, including LAIs, are reimbursed based on place of service. This is designed, in part, to ensure that payment is appropriate based on the benefit and provider type. ASP is designed for appropriate reimbursement for drugs administered in a clinic or physician office setting, and includes rebates, discounts, and other price concessions between a drug manufacturer and clinics. Pharmacy reimbursement methodologies reflect appropriate payments for drugs administered in a pharmacy setting.<sup>33</sup>
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The Department believes that, if approved, the request for funding from the General Assembly mentioned above will allow for more appropriate reimbursement for LAIs and negate any need to move these drugs to the pharmacy benefit.

## **Fiscal Analysis**

### Physician-Administered Drug Recommendation 1

If the Department were to reimburse for physician-administered drugs at “ASP Plus” pricing, effective January 1, 2018, the expected change in expenditure would be as follows:

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<sup>33</sup> Two of the primary reimbursement statistics that are used to calculate pharmacy reimbursement are average acquisition cost (AAC) and wholesale acquisition cost (WAC). AAC is calculated by using invoices and/or purchase records from a representative number of pharmacies. WAC represents the manufacturer’s list price for a drug to wholesalers or direct purchasers and is determined at a national-level by an independent entity, First Databank.



| <b>Estimated Impact of Using "ASP Plus" Pricing for Physician-Administered Drugs<sup>34</sup></b> |                    |                     |                   |                      |
|---------------------------------------------------------------------------------------------------|--------------------|---------------------|-------------------|----------------------|
| <b>Item</b>                                                                                       | <b>Total Funds</b> | <b>General Fund</b> | <b>Cash Funds</b> | <b>Federal Funds</b> |
| <i>Average Sales Price</i>                                                                        |                    |                     |                   |                      |
| FY 2017-18 Annual Impact                                                                          | (\$444,347)        | (\$130,931)         | (\$16,485)        | (\$296,931)          |
| FY 2018-19 Annual Impact                                                                          | \$1,038,122        | \$305,797           | \$42,246          | \$690,079            |
| FY 2019-20 Annual Impact                                                                          | \$3,339,277        | \$983,642           | \$147,591         | \$2,208,044          |
| <i>Average Sales Price + 2.5%</i>                                                                 |                    |                     |                   |                      |
| FY 2017-18 Annual Impact                                                                          | \$39,320           | \$11,586            | \$1,459           | \$26,275             |
| FY 2018-19 Annual Impact                                                                          | \$2,164,801        | \$637,679           | \$88,097          | \$1,439,025          |
| FY 2019-20 Annual Impact                                                                          | \$4,545,507        | \$1,338,958         | \$200,904         | \$3,005,645          |
| <i>Average Sales Price + 6%</i>                                                                   |                    |                     |                   |                      |
| FY 2017-18 Annual Impact                                                                          | \$716,454          | \$211,109           | \$26,581          | \$478,764            |
| FY 2018-19 Annual Impact                                                                          | \$3,742,154        | \$1,102,316         | \$152,287         | \$2,487,551          |
| FY 2019-20 Annual Impact                                                                          | \$6,234,235        | \$1,836,401         | \$275,544         | \$4,122,290          |

### Physician-Administered Drug Recommendation 2

The Department has investigated this recommendation and does not support moving LAIs from the physician services benefit to the pharmacy benefit. As such, the Department does not need additional resources to investigate this MPRRAC recommendation.

### Physician-Administered Drug Recommendation 3

Based on the MPRRAC's recommendation, the Department does not need additional resources at this time to continue the rate setting process.

### **Department Recommendation**

The Department recommends a change to physician-administered drug rates. This is informed by further analysis and discussion subsequent to submission of the 2016 Analysis Report. As part of the Governor's November 1, 2016 executive budget request R-7, "Oversight of State Resources", the Department is requesting to update the pricing for physician-administered drugs on a periodic basis consistent with pricing for other drugs. The Department is requesting to set rates based on an average of 2.5% over ASP effective January 1, 2018. The Department is also requesting funding for 1.0 FTE to act

<sup>34</sup> After conversations with committee members and stakeholders, the Department estimated the fiscal impact of pricing at ASP, ASP +2.5%, and ASP +6%. These percentages were used because current Medicare reimbursement is ASP +6% and there is a proposed rule from CMS to change Medicare reimbursement to ASP +2.5%.



as a benefits manager for physician-administered drugs, and to account for savings associated with reduced hospital visits as a result of better physician-administered drug availability. If approved as requested, these changes would allow the Department to implement and fulfill MPRRAC's Physician-Administered Drugs Recommendation 1.

For the reasons outlined in the Department Considerations section above, the Department does not plan to conduct further investigation regarding moving LAIs from the physician services benefit to the pharmacy benefit.

The Department will continue with its current rate setting process, in alignment with MPRRAC's third recommendation.

