



COLORADO

Department of Health Care
Policy & Financing

2023 Medicaid Provider Rate Review Analysis and Recommendation Report

November 1, 2023

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

This report was updated on November 16, 2023 to correct
inaccuracies, noted herein as “(correction)”.

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Executive Summary

This report contains the Colorado Department of Health Care Policy & Financing’s (HCPF) review of rates paid to providers under the Colorado Medical Assistance Act. This report is intended to be used by HCPF, in collaboration with the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and stakeholders, to evaluate findings and generate recommendations. Senate Bill 23-223 Medicaid Provider Rate Review Process reduced the rate review cycle so that each provider type is reviewed every three years instead of every five years. Services under review this year, Year One of the first three-year review cycle, are listed in the table below. The Rate Review Process, enacted in June 2015 by Senate Bill 15-228 and amended in June 2022 by Senate Bill 22-236 and June 2023 by Senate Bill 23-223, operates in accordance with the Colorado Medical Assistance Act, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes).

This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder feedback, additional research, and recommendations for each service under review this year. The services are a subset of services reviewed throughout the entire three-year cycle. For each service grouping, rate benchmark comparisons describe (as a percentage) how Colorado Medicaid payments compare to other payers and are listed below.

Services Rate Benchmark Comparison Results	
Service	CO as a Percent of Benchmark
Anesthesia	137.5%
Ambulatory Surgical Centers	53.5%
Fee-for-Service Behavioral Health Services	97.0%
Pediatric Behavioral Therapy	78.7% for Method 1 - Including Nebraska; 90.7% for Method 2 - Excluding Nebraska
Maternity Services	76.1%
Abortion Services	N/A
Dental Services	49.8%

Table 1. Rate Benchmark Comparison Results

Surgeries Rate Benchmark Comparison Results	
Service	CO as a Percent of Benchmark
Digestive System	96.4%
Musculoskeletal System	66.4%
Cardiovascular System ¹	162.4%
Respiratory System	82.5%
Integumentary System	63.5%

¹ Here the benchmark ratio for cardiovascular surgery service is based on the repricing methodology which is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. In addition, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service."



Eye and Auditory System	95.0%
Other Surgeries	78.2%

Table 2. Surgeries Rate Benchmark Comparison Results

Using the recommendations from the MPRRAC process, HCPF staff prepare recommendations in accordance with anticipated budget restrictions for the coming fiscal year such as budget projections, HCPF's overall budget, and HCPF's budget relative to other state budget priorities. HCPF considers the MPRRAC's recommendations seriously when prioritizing HCPF recommendations; however, the budget allowance may not allow HCPF and MPRRAC recommendations to align.

The total anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **\$144,027,428 total funds, and \$39,718,024 General Fund.**

The total anticipated fiscal impact of HCPF's recommendations is predicted to be **\$112,395,679 total funds, and \$28,271,871 General Fund.**

Members of the public are invited to engage in the Rate Review Process; provide input on access, quality, and provider rates; and attend MPRRAC meetings. The three-year rate review schedule, the MPRRAC meeting schedule, past MPRRAC meeting materials, and more can be found on HCPF [website](#).

Anesthesia

MPRRAC Recommendations:

- The MPRRAC suggests consideration of the difference between moderate and general sedation when it comes to reimbursement rates.
- Introduce a travel rate for anesthesia providers due to additional travel costs and an expected improvement of access to care.
- The MPRRAC members support reducing the rate to 100% of the benchmark, but voiced two main concerns:
 - Increased cost to supplies (example: COVID-19 protocols, supply chain issues, inflation).
 - Decreases may impact certain codes more than others.
- The anticipated fiscal impact of MPRRAC's recommendations is predicted to be **(\$9,897,967) total funds, (\$2,896,344) General Fund.**

HCPF Recommendations:

- HCPF recommends a reduction in anesthesia service rates to 100% of the benchmark, which would be more in line with target and other providers, while allowing for funding to be more equitably distributed to other provider types.



- The anticipated fiscal impact of HCPF’s recommendations is predicted to be **(\$9,897,967) total funds, and (\$2,896,344) General Fund.**

Ambulatory Surgical Centers (ASCs)

MRRAC Recommendations:

- The MRRAC recommends an increase of ASC rates to at least 80% of the benchmark.
 - This is equivalent to increasing the current rates by 26.5% (correction).
- The anticipated fiscal impact of the MRRAC’s recommendations is predicted to be **\$5,379,889 total funds, \$1,574,264 General Fund.**

HCPF Recommendations:

- HCPF recommends increasing ASC rates to 75% of the benchmark to encourage utilization of the ASC setting.
 - This is equivalent to increasing the current rates by 21.5%.
 - ASCs are an alternative care site to the outpatient hospital care site; adequate ASC access creates a cost efficient care alternative
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$4,366,634 total funds, \$1,277,764 General Fund.**

Fee-for Service (FFS) Behavioral Health Services

MRRAC Recommendations:

- The MRRAC recommends a language translation modifier for native language speakers for testing codes.
- The MRRAC recommends reviewing four psychological testing codes (96132, 96133, 96136, 96137) under fee-for-service behavioral health services, as opposed to reviewing under Physician Services category as done previously in the [2022 Medicaid Provider Rate Review Analysis Report](#).
 - Some members support a higher increase above 100%, while others recommend looking at specific codes (96132, 96133, 96136, 96137) to be above 100% in order to alleviate the bottleneck in accessing psychological assessments.
- The anticipated fiscal impact of the MRRAC’s recommendation is predicted to be **\$319,452 total funds, \$159,726 General Fund.**

HCPF Recommendations:

- HCPF recommends reverting the rates for 2 ASD/Development screening assessment codes (96110 and 96127) to \$18.39 to reflect the rates before the 2019/2022 MPRRAC review plus the 3% across-the-board rate increase applied for FY 2023-24.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$1,664,157 total funds, \$822,078 General Fund.**

Pediatric Behavioral Therapy (PBT)

MPRRAC Recommendations:

- The MPRRAC recommends increasing PBT rates to 100% of the benchmark that includes Nebraska (78.7%) and open up a list of codes that are not currently covered by Colorado Medicaid.
 - Codes include: 97152, 97156, 97157, 0362T, 0373T
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$34,281,532 total funds, \$17,140,766 General Fund.**

HCPF Recommendations:

- HCPF recommends raising all rates to 100% of the benchmark, excluding Nebraska (90.7%).
 - Nebraska is an extreme outlier with rates that are between 41% - 508% above other states in the benchmark cohort. For example, the Nebraska rate for 97155 per unit is \$36.11 in 2023, which is 41% higher than the average rate of other nine states. Its rate for 97158 per unit is \$54.17, which is 508% higher than the average rate of other nine states.
 - Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year’s rate increases.
- HCPF recommends leaving one procedure code (97158) at its current rate because its benchmark ratio is already at 128.5%, which is above the recommended 100% benchmark ratio of other four procedure codes.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$13,019,386 total funds, \$6,509,693 General Fund.**

Maternity Services

MPRRAC Recommendations:



- The MPRRAC recommends an increase of maternity rates to 100% of the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$8,942,246 total funds, \$4,471,123 General Fund.**

HCPF Recommendations:

- HCPF recommends 13 out of 18 general maternity service and care codes increase to 100% of the benchmark (59160, 59300, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59614, 59618, 59622, 59830).
 - HCPF recommends that the 5 out of 18 general maternity service and care codes that are already above 90% remain at their current rate (59350, 59409, 59525, 59612, 59614).
- HCPF recommends 12 out of 14 non-viable pregnancy codes increase to 80% of the benchmark (59070, 59120, 59121, 59130, 59150, 59001, 59015, 59200, 59812, 59820, 59821, 59870).
 - HCPF recommends that the 2 out of 14 non-viable pregnancy codes that are above 80% remain at their current rate (59025, 59151).
- HCPF recommends the 10 OB Global Bundled codes remain at their current rate (59000, 59012, 59051, 59140, 59320, 59412, 59414, 59514, 59620, 59871).
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$8,494,404 total funds, \$4,247,202 General Fund.**

Abortion Services

MPRRAC Recommendations:

- The MPRRAC recommends increasing rates closer to other states’ Medicaid programs because the rates are only reviewed every three years.
- One suggestion is a targeted rate increase because there is insufficient information due to HIPAA prohibiting the disclosure of codes with less than 30 claims; the MPRRAC raised concerns about how a rate increase may impact other services’ rate increases:
 - Concerns about using different states as a benchmark because other factors may not be comparable to Colorado.
 - Concerns that Medicare is not used as the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is \$0.

HCPF Recommendations:



- HCPF recommends raising the reimbursement rate for code 59840 (Dilation and Curettage) to \$354.54
- HCPF recommends raising the reimbursement rate for code 59841 (Dilation and Evacuation) to \$1,150.00.
- The anticipated fiscal impact of HCPF’s recommendations is predicted to be **\$325 total funds, \$162 General Fund.**

Dental Services

MPRRAC Recommendations:

- The MPRRAC recommends that the 24 preventative, endodontic, periodontic and diagnostic dental codes submitted by the Colorado Dental Association be increased to 100% of the commercial benchmark to have the most immediate impact on the dental community. These 24 dental codes are high value codes with the most immediate impact on the Colorado dental community.
- The 24 identified codes are: D0120, D0140, D0150, D1110, D1120, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930, D3310, D3320, D3330, D3346, D3347, D3348, D4341, D4342, and D4910.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$104,138,137 total funds, \$19,015,624 General Fund.**

HCPF Recommendations:

- HCPF recommends increasing preventative dental codes (D1110, D1120), endodontic codes (D3310, D3320, D3330, D3346, D3347, D3348) and periodontic codes (D4341, D4342 and D4910) to 100% of the benchmark. This aligns with incentivizing dental prevention and efforts to improve member access and equity in oral health care.
- HCPF recommends the remaining 13 codes for diagnostic services (D0120, D0140, D0150, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930) increase to 70% of the benchmark.
- HCPF recommends raising 4 additional preventative procedure codes: D1206, D1351, D1352, D1354 (3 codes are for sealants and 1 is for silver diamine fluoride to arrest decay) to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$85,620,023 total funds, \$15,634,217 General Fund.**

Digestive System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends keeping preventative surgery codes at 100% of the benchmark.
 - Preventative surgery codes include:
 - 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.
- For all other codes, rebalance to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **(\$1,447,136) total funds, (\$423,461) General Fund.**

HCPF Recommendations:

- HCPF recommends raising preventative surgery codes to 100% of the benchmark and keeping any preventative codes over 100% at their current rate.
 - Preventative surgery codes include: 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.
- HCPF recommends a rebalance of all other codes, meaning codes below 70% of the benchmark be increased to 70%, and codes above 100% of the benchmark be reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **(\$1,165,252) total funds, (\$340,976) General Fund.**

Musculoskeletal System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$5,003,658 total funds, \$1,464,171 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes, with codes below the 70% benchmark increased to 70% and codes above 100% of the benchmark reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$3,732,671 total funds, \$1,092,254 General Fund.**

Cardiovascular System Surgeries

MPRRAC Recommendations:



- The MPRRAC recommends a rebalancing of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **(\$7,723,131) total funds, (\$2,259,943) General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 125% of the benchmark to be reduced to 125% using only non-facility Medicare rates as the benchmark.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **\$2,842,496 total funds, \$831,772 General Fund.**

Respiratory System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$180,879 total funds, \$52,929 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be **(\$223,909) total funds, (\$65,520) General Fund.**

Integumentary System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **\$3,216,801 total funds, \$941,300 General Fund.**

HCPF Recommendations:



- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
 - HCPF recommends 1 preventative code (17380) to increase to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **\$2,081,628 total funds, \$609,126 General Fund.**

Eye and Auditory Systems Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **(\$176,581) total funds, (\$51,671) General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **(\$383,945) total funds, (\$112,350) General Fund.**

Other Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **\$1,809,649 total funds, \$529,540 General Fund.**

HCPF Recommendations:

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be **\$505,358 total funds, \$147,878 General Fund.**

Co-Surgery

MRRAC Recommendations:

- The MRRAC did not receive data on Co-Surgery, and therefore did not make a recommendation.

HCPF Recommendations:

- HCPF recommends to expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes 2,469 codes.
- The anticipated fiscal impact of the co-surgery recommendation is about **\$1,759,670 total funds, \$514,915 General Fund.**



Introduction

The Colorado Department of Health Care Policy & Financing (HCPF) administers the State’s public health insurance programs, including Colorado’s Medicaid, Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. HCPF’s mission is to improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

In 2015, the Colorado General Assembly adopted Senate Bill 15-228, “Medicaid Provider Rate Review,” amended by Senate Bill 22-236 in 2022, an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with the Colorado Medical Assistance ACT, Section 25.5-4-401, C.R.S. (Colorado Revised Statutes), HCPF established a rate review process that involves three components:

- assess and, if needed, review a three-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review;
- provide recommendations on all rates reviewed and present them in a report published the first of every November.

The Rate Review Process is advised by the MPRRAC, whose members recommend changes to the three-year schedule, provide input on reports published by HCPF, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year One of the first three-year rate review cycle, began in March 2023 and included a general discussion of services under review and stakeholder feedback. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are found on HCPF [website](#).

This report contains:

- comparisons of Colorado Medicaid provider rates to those of other payers;
- access to care analyses; and
- assessments of whether payments were sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services, including where additional research is necessary to identify potential access issues.



Payment Philosophy

The Rate Review Process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process, which includes feedback from the MPRRAC, has helped inform HCPF's payment philosophy for fee-for-service (FFS) rates.

Where Medicare is an appropriate comparator, HCPF believes that, in many circumstances, a reasonable threshold for payments is 80% - 100% of Medicare; however, there are four primary situations where Medicare may not be an appropriate model when comparing a rate, including, but not limited to:

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., dental & maternity services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid.
3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar (e.g., some health education services).
4. There is a known issue with Medicare's rates (e.g., home health services).

When Medicare is not an appropriate comparator, HCPF may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While HCPF has historically viewed payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below, must be considered when setting or changing a rate. These include:

- budget constraints that may prevent payment at a certain amount;
- investigating whether a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies;
- identifying certain services where HCPF may want to adjust rates to incentivize utilization of high value services;
- complaints received from primary care physicians (PCP) and members indicating that specialists, while enrolled in the Medicaid network, are not accepting Medicaid patients for care, thus impeding member access; the access appears to exist measured by specialty provider enrollment but is not equally presenting via the patient or PCP experience; and
- developing systems to ensure that payments are associated with high-quality provision of services.

When the Rate Review Process indicates a current rate does not align with HCPF's payment philosophy, HCPF may recommend or implement a rate change. It is also important to note that HCPF may or may not recommend a change, due to the considerations listed above.

Format of Report

Information below explains the sections within each service grouping of the report, including each section's basic structure and content.

Service Description

Service definitions, procedure or revenue codes, and member and provider data are outlined in this section. This section is designed to provide the reader with an understanding of the service grouping under review, as well as the scale of members utilizing and providers delivering this service grouping. Summary statistics are provided for each service grouping. Those statistics and time period they represent are:

- Total Adjusted Expenditures - FY 2021-22.
- Total Members Utilizing Services - FY 2021-22.
- Year-over-year Change in Members Utilizing Services - FY 2020-21 - FY 2021-22
- Total Active Providers - FY 2021-22.
- Year-over-year Change in Active Providers - FY 2020-21 - FY 2021-22

Rate Comparison Analysis

HCPF contracted with the actuarial firm, Optumas, to assist in the comparison of Colorado Medicaid provider rates to those of other payers. The resulting rate comparison analysis outlined in this section provides a reference point for how Colorado Medicaid reimbursement rates compare to other payers.

Analysis in this section is based on FY 2021-22 administrative claims data and contains a rate benchmark comparison, which describes (as a percentage) how Colorado Medicaid payments compare to other payers. This section also lists the number of procedure codes compared to either Medicare or an average of other states' Medicaid rates, and the range of individual rate ratios.

HCPF first examined whether a service had a corresponding Medicare rate to identify comparator rates for analysis. Medicare rates were primarily relied upon for this analysis when available and appropriate. When Medicare rates were unavailable, HCPF relied upon other state Medicaid agency rates when the benchmark states have applicable fee-for-service rates for the service category. HCPF utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates;
- Medicare’s rates, methodologies, and service definitions are generally available to the public;
- Medicare’s rates are typically updated on a periodic basis; and
- Most services covered by Colorado Medicaid are also covered by the Medicare program.

Access to Care Analysis

HCPF contracted with the Center for Improving Value in Health Care (CIVHC) to assist in evaluating access. The access to care analysis shows provider participation within each service under review. It should be noted that this metric does not measure actual utilization compared to network enrollment, creating an opportunity going forward. Again, a provider may be enrolled in Medicaid but is not accepting patient referrals, due to Medicaid reimbursement rates or other factors. HCPF is now reviewing all enrolled specialists to identify providers not seeing enough Medicaid members. For the purposes of this current report the current access to care metrics do not indicate how Colorado Medicaid members’ access to services in those regions compared to access for individuals with other insurance, or to the uninsured population. HCPF and MPRRAC will explore ways to expand the access to care analysis in future review cycles.

Stakeholder Feedback

This section contains summaries of stakeholder comments received during the Rate Review Process.

Additional Research

For certain service groupings and regions, particularly when HCPF’s analysis indicated a potential access issue, HCPF will work to identify other data sources that may be used to conduct additional research during the MPRRAC process. These data sources may be created and maintained as part of HCPF’s ongoing benefit management and programmatic operations, while others may be created by other organizations or State agencies. HCPF plans to use these data sources to conduct further research as HCPF’s 2023 Medicaid Provider Rate Review Analysis Report is developed. Options for additional research include:



- Examining claims and enrollment data to understand if members are accessing services in settings, or via delivery systems, that are excluded from the rate review analysis.
- Reviewing relevant, regional results on Key Performance Indicators (KPIs), which are tracked as a part of Colorado Medicaid’s delivery system, the Accountable Care Collaborative.
- Reviewing relevant, practice-level results on quality metrics, including Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures.
- Working with HCPF’s provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.
- Seeking information from the State Health Care Workforce Work team to determine the general impact of health care workforce burnout, inflation, and health care workforce shortages to understand how Medicaid reimbursement rates might have to be adjusted due to these COVID19 induced factors.
- Examining regional and statewide reports and studies published by other agencies, such as the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Recommendations

This section lists MPRRAC’s and HCPF’s recommendations for Year One (Cycle One) services as a result of the Rate Review Process. Additionally, stakeholder feedback during MPRRAC meetings is helpful for identifying additional areas for evaluation. For these reasons, some recommendations focus on further research rather than direct action on rates or policy.

Limitations

Results from this report, emerging macro and micro environmental factors (i.e.: inflation, health care workforce burnout, health care workforce shortages, etc.) and additional research will inform the development of HCPF Recommendations. Still, it is important to note limitations inherent to analyses in this report and limitations that exist generally when evaluating payment sufficiency and access to care.

The access to care analyses and resulting conclusions are based on administrative claims data. Claims-based analyses do not provide information regarding appointment



wait times, quality of care, or differences in provider availability and service utilization based on insurance type; nor do claims-based analyses allow for HCPF to quantify care that an individual may have needed but did not receive nor the provider enrollment versus providers seeing Medicaid patients. In addition, data analyses use active providers, which includes any rendering provider with at least one Colorado Medicaid paid claim in a given month between July 2021 - June 2022. HCPF plans to create additional internal insight reports and to evaluate other data sources to address this. When HCPF evaluates other data sources, there may be assumptions and extrapolations made due to differences in geographic area designations, differences in population definitions, and differences in service definitions. Additionally, many of the access to care indicators are relative, and without defined standards, cannot indicate if all regions are performing well or if all regions are performing poorly. However, these indicators, when analyzed all together, can help identify regions for focus.

There are complicating factors regarding determining rate sufficiency. Member access and provider retention are influenced by factors beyond rates, such as: provider outreach and recruitment strategies; the administrative burden of program participation; health literacy and healthcare system navigation ability; provider scheduling and operational practices; and member characteristics and behaviors. Additionally, rates may not be at their optimal level, even when there is no indication of member access or provider retention issues. For example, rates that are above optimal may lead to decreases in the provision of high-quality care or increases in the provision of services in a less cost-effective setting.



Anesthesia

Service Description

The anesthesia service grouping consists of 291 procedure codes (including reviewed and excluded procedure codes). Anesthesia includes general, local, and conscious sedation done to permit the performance of medical, surgical, and radiological procedures. Anesthesia services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Anesthesia Statistics	
Total Adjusted Expenditures FY 2021-22	\$34,584,601
Total Members Utilizing Services in FY 2021-22	90,868
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	3.9%
Total Active Providers FY 2021-22	1,764
FY 2021-22 Over FY 2020-21 Change in Active Providers	2.3%

Table 3. Anesthesia expenditure and utilization data (FY 2021-22).

Rate Comparison Analysis

On average, Colorado Medicaid payments for anesthesia services are estimated at 137.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Anesthesia Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$36,268,689	\$26,370,722	137.5%

Table 4. Comparison of Colorado Medicaid anesthesia service payments to those of other payers expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be (\$9,897,967) total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 291 procedure codes analyzed in this service grouping, 246 were compared to Medicare (84.5%), 39 did not have applicable repricing rates, and 6 did not have valid utilization in FY 2021-22. Individual rate ratios for anesthesia services were 129% - 271.7%.

Access to Care Analysis

The provider participation rate for anesthesia services is 53%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

In 2020, HCPF lowered anesthesia rates to match Medicare rates, however; in 2021 Medicare lowered their rates once again which left the state of Colorado's rates higher than Medicare. HCPF was unaware of the difference in rates until research and data were pulled for this report.

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	00840	ANESTH SURG LOWER ABDOMEN	\$ 2,395,330	\$ 2,520,471	\$ 1,855,995	135.8%
2	00731	ANES UPR GI NDSC PX NOS	\$ 2,227,284	\$ 2,340,760	\$ 1,723,416	135.8%
3	01967	ANESTH/ANALG VAG DELIVERY	\$ 2,212,667	\$ 2,330,266	\$ 1,701,946	136.9%
4	00790	ANESTH SURG UPPER ABDOMEN	\$ 2,011,803	\$ 2,114,520	\$ 1,558,012	135.7%
5	00170	ANESTH PROCEDURE ON MOUTH	\$ 1,773,391	\$ 1,863,439	\$ 1,372,739	135.7%
6	01961	ANESTH CS DELIVERY	\$ 1,156,876	\$ 1,215,022	\$ 829,556	146.5%
7	00670	ANESTH SPINE CORD SURGERY	\$ 1,076,582	\$ 1,131,195	\$ 833,570	135.7%
8	01480	ANESTH LOWER LEG BONE SURG	\$ 983,851	\$ 1,033,660	\$ 761,279	135.8%
9	01922	ANESTH CAT OR MRI SCAN	\$ 967,917	\$ 1,017,433	\$ 748,485	135.9%
10	00811	ANES LWR INTST NDSC NOS	\$ 938,046	\$ 985,800	\$ 726,182	135.8%

Table 5. Top 10 codes utilized for anesthesia services (FY 2021-22).

HCPF identified 25 outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
01968	ANES/ANALG CS DELIVER ADD-ON	\$ 236,571	\$ 180,950	\$ 128,431	140.9%
00540	ANESTH CHEST SURGERY	\$ 61,547	\$ 64,664	\$ 45,737	141.4%
00865	ANESTH REMOVAL OF PROSTATE	\$ 35,730	\$ 37,555	\$ 26,446	142.0%
01925	ANESTH INTERVEN RAD CARD	\$ 18,478	\$ 19,413	\$ 13,554	143.2%
01924	ANESTH INTERVEN RAD ARTRL	\$ 96,544	\$ 101,430	\$ 70,313	144.3%
01931	ANESTH INTERVEN RAD TIPS	\$ 40,369	\$ 42,413	\$ 29,215	145.2%
01960	ANESTH VAGINAL DELIVERY	\$ 1,958	\$ 2,077	\$ 1,427	145.6%
00567	ANESTH CABG W/PUMP	\$ 109,087	\$ 114,656	\$ 78,412	146.2%
01961	ANESTH CS DELIVERY	\$ 1,156,876	\$ 1,215,022	\$ 829,556	146.5%
01933	ANES TX INTERV RAD CRAN VEIN	\$ 2,729	\$ 2,868	\$ 1,956	146.6%
00834	ANESTH HERNIA REPAIR < 1 YR	\$ 12,541	\$ 13,176	\$ 8,934	147.5%
01770	ANESTH UPPR ARM ARTERY SURG	\$ 13,703	\$ 14,397	\$ 9,729	148.0%
00851	ANESTH TUBAL LIGATION	\$ 135,080	\$ 141,329	\$ 94,914	148.9%
01963	ANESTH CS HYSTERECTOMY	\$ 1,161	\$ 1,220	\$ 815	149.7%
01926	ANES TX INTERV RAD HRT/CRAN	\$ 203,665	\$ 214,017	\$ 142,131	150.6%
01214	ANESTH HIP ARTHROPLASTY	\$ 340,959	\$ 358,281	\$ 236,454	151.5%
00147	ANESTH IRIDECTOMY	\$ 877	\$ 922	\$ 595	154.9%
01930	ANESTH INTERVEN RAD VEIN	\$ 84,478	\$ 88,788	\$ 57,319	154.9%
01932	ANES TX INTERV RAD TH VEIN	\$ 6,743	\$ 7,084	\$ 4,537	156.1%
01952	ANESTH BURN 4-9 PERCENT	\$ 83,657	\$ 87,892	\$ 52,731	166.7%
00326	ANESTH LARYNX/TRACH < 1 YR	\$ 64,750	\$ 68,037	\$ 40,499	168.0%
00142	ANESTH LENS SURGERY	\$ 491,864	\$ 516,932	\$ 283,291	182.5%
01951	ANESTH BURN LESS 4 PERCENT	\$ 30,874	\$ 32,457	\$ 15,469	209.8%
01953	ANESTH BURN EACH 9 PERCENT	\$ 14,632	\$ 496	\$ 197	251.9%
00635	ANESTH LUMBAR PUNCTURE	\$ 208,074	\$ 218,718	\$ 80,493	271.7%

Table 6. Outliers for anesthesia services (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.



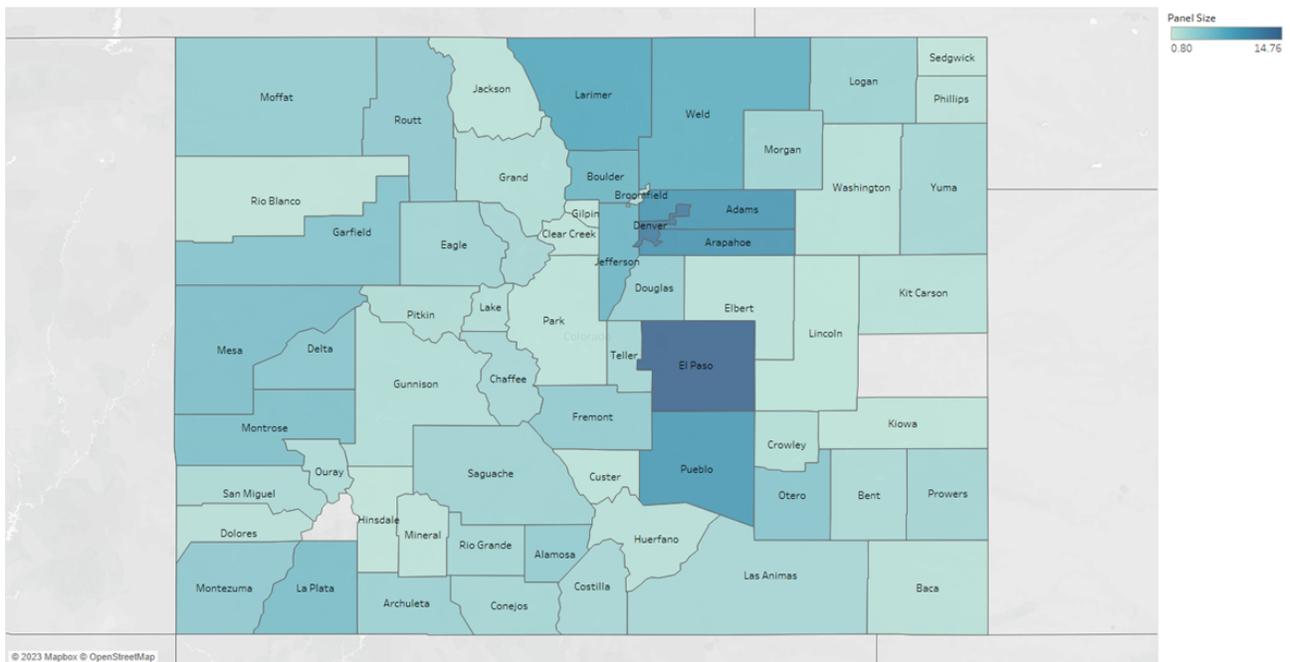


Figure 1. Anesthesia utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC suggests consideration of the difference between moderate and general sedation when it comes to reimbursement rates.
- The MPRRAC recommends introducing a travel rate for anesthesia providers due to additional travel costs and an expected improvement of access to care.
- The MPRRAC members support bringing down the rate to 100% of the benchmark, however voiced two main concerns:
 - Increase of cost to supplies (example: COVID-19 protocols, supply chain issues, inflation).
 - Decreases may impact certain codes more than others.
- The anticipated fiscal impact of MPRRAC's recommendations is predicted to be (\$9,897,967) total funds, (\$2,896,344) General Fund.

HCPF Recommendations

- HCPF recommends a reduction in anesthesia service rates to 100% of the benchmark.
- The anticipated fiscal impact of HCPF's recommendations is predicted to be (\$9,897,967) total funds, and (\$2,896,344) General Fund.

Policy Justification

HCPF agrees with MPRRAC’s recommendation to bring rates down to 100% of the benchmark. However, HCPF disagrees with introducing a travel rate for traveling anesthesia providers because HCPF does not have a clear idea of what travel rates for anesthesia providers would look like or how it would function in practice. HCPF does not currently have any way to differentiate services by traveling anesthesiologists from other anesthesia services so it’s difficult to estimate what kind of expenditure this would be. If HCPF were to identify a modifier, providers could use this to indicate travel that would correspond to a higher rate. HCPF would also need to implement some kind of oversight that currently does not exist to ensure appropriate utilization.

Ambulatory Surgical Centers

Service Description

The ambulatory surgical centers (ASCs) service grouping comprises 11 groupers. ASCs are distinct entities that provide a surgical setting for members who do not require hospitalization. ASC services were previously reviewed in the [2019 Medicaid Provider Rate Review Analysis Report](#).

Ambulatory Surgical Centers Statistics	
Total Adjusted Expenditures FY 2021-22	\$13,381,112
Total Members Utilizing Services in FY 2021-22	21,795
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	9.6%
Total Active Providers FY 2021-22	305
FY 2021-22 Over FY 2020-21 Change in Active Providers	12.1%

Table 7. Ambulatory Surgical Centers expenditure and utilization data (FY 2021-22).

Rate Comparison Analysis

On average, Colorado Medicaid payments for ASC services are estimated at 53.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Ambulatory Surgical Centers Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$10,832,192	\$20,265,101	53.5%

Table 8. Comparison of Colorado Medicaid Ambulatory Surgical Centers service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$9,432,909 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 11 groupers analyzed in this service grouping, 10 were compared to Medicare (90.9%), and 1 did not have valid utilization during FY 2021-22. Grouper rate ratios for ASCs services were 26.2% - 79.5%.

Access to Care Analysis

The provider participation rate for ASC services is 43%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. However, comparison by procedure code was not an accurate representation for the ASC service category due to differences in payment methodologies between Medicare and Colorado Medicaid. Instead, HCPF compared payments in aggregate by ASC grouper. Payments were combined for each procedure code in each grouper for Medicaid and Medicare, then aggregate Medicaid payments were divided by aggregate Medicare payments. The table on the right depicts the benchmark percentages using the discounts under Medicare for multiple procedures done at the same time.

Repriced Medicare - Primary Line Only				Repriced Medicare - Multiple Procedure Discount			
Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark	Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A01	\$ 2,063,865	\$ 3,627,303	56.9%	A01	\$ 2,063,865	\$ 4,306,859	47.9%
A02	\$ 3,792,552	\$ 5,700,607	66.5%	A02	\$ 3,792,552	\$ 7,054,236	53.8%
A03	\$ 834,843	\$ 3,187,907	26.2%	A03	\$ 834,843	\$ 3,941,267	21.2%
A04	\$ 603,662	\$ 1,702,973	35.4%	A04	\$ 603,662	\$ 1,961,016	30.8%
A05	\$ 595,826	\$ 1,605,658	37.1%	A05	\$ 595,826	\$ 1,707,423	34.9%
A06	\$ 250,098	\$ 738,342	33.9%	A06	\$ 250,098	\$ 781,022	32.0%
A07	\$ 253,733	\$ 611,368	41.5%	A07	\$ 253,733	\$ 628,474	40.4%
A08	\$ 1,629,422	\$ 2,050,309	79.5%	A08	\$ 1,629,422	\$ 2,068,211	78.8%
A09	\$ 383,337	\$ 505,154	75.9%	A09	\$ 383,337	\$ 524,014	73.2%
A10	\$ 424,854	\$ 535,480	79.3%	A10	\$ 424,854	\$ 565,387	75.1%
A11	\$ -	\$ -	0.0%	A11	\$ -	\$ -	0.0%
Total	\$ 10,832,192	\$ 20,265,101	53.5%	Total	\$ 10,832,192	\$ 23,537,908	46.0%

Table 9. The table on the left shows Medicaid payments compared to Medicare if Medicare used the same payment methodology as the State of Colorado while the table on the right shows the rate comparison with Medicare's multiple procedure discounting methodology included in the Medicare repricing. (FY 2021-22).

HCPF identified 6 ASC grouper outliers:

Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A03	\$ 834,843	\$ 3,187,907	26.2%
A06	\$ 250,098	\$ 738,342	33.9%
A04	\$ 603,662	\$ 1,702,973	35.4%
A05	\$ 595,826	\$ 1,605,658	37.1%
A07	\$ 253,733	\$ 611,368	41.5%
A01	\$ 2,063,865	\$ 3,627,303	56.9%

Table 10. Outlier for ASC services (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

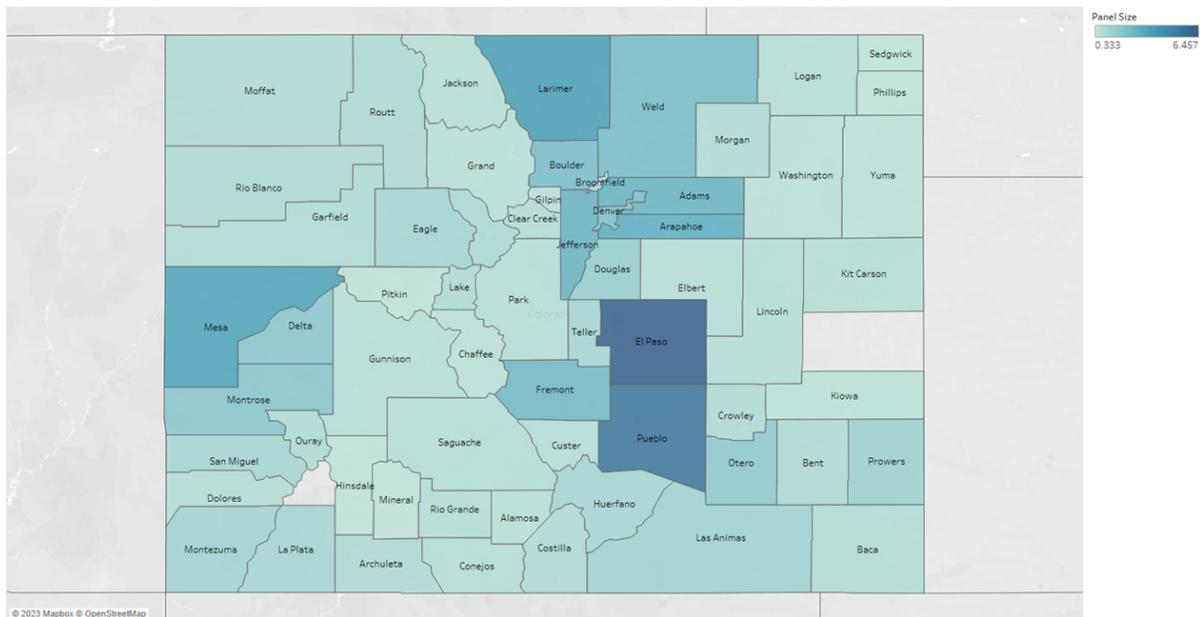


Figure 2. ASC utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends an increase of ASC rates to at least 80% of the benchmark.
 - This is equivalent to increasing the current rates by 26.5% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be \$5,379,889 total funds, \$1,574,264 General Fund.

HCPF Recommendations

- HCPF recommends a reform in payment methodology for ASC providers to the existing Enhanced Ambulatory Patient Grouper methodology utilized for Outpatient Hospital claims.
- HCPF recommends increasing ASC rates to 75% of the benchmark.
 - This is equivalent to increasing the current rates by 21.5%
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$4,366,634 total funds, \$1,277,764 General Fund.

Policy Justification

HCPF recommends an increase to 75% of the benchmark rather than MPRRAC's 80% in an effort to encourage greater utilization of lower-cost options for surgeries while working towards an updated payment methodology that will address the majority of

ASC rate concerns. Further, the benchmark is an inaccurate comparison because Medicare does not pay the same way that Medicaid pays.

Fee-for-Service Behavioral Health Services

Service Description

The fee-for-service (FFS) behavioral health service grouping consists of 31 procedure codes. HCPF pays for a small number of behavioral health services directly (FFS), outside of the Capitated Behavioral Health Benefit. A behavioral health code is paid FFS when the service is provided for a diagnosis not covered in the managed care benefit, such as when a psychological assessment is required for a surgical procedure; if it is not a procedure covered by managed care benefit, such as developmental testing even if completed by a psychologist; or if it is billed for a member who is not assigned to a regional accountable entity, usually due to retroactive billing for newly enrolled members. This set of codes reviewed was specific to mental health and neuropsychological codes, and does not include substance use codes. Additionally, the Short Term Behavioral Health Visit benefit is reimbursed by FFS. It is limited to six visits per member per year. Only FFS behavioral health rates are included in the analysis. Most codes under FFS behavioral health services were previously reviewed in the [2019 Medicaid Provider Rate Review Analysis Report](#). However, some codes that are now under FFS behavioral health services were previously reviewed under Physician - Cognitive Capabilities in the [2022 Medicaid Provider Rate Review Analysis Report](#).

Fee-for-Service Behavioral Health Services Statistics	
Total Adjusted Expenditures FY 2021-22	\$18,734,736
Total Members Utilizing Services in FY 2021-22	112,683
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	8.8%
Total Active Providers Billing FFS BH in FY 2021-22	3,699
FY 2021-22 Over FY 2020-21 Change in Active Providers	12.5%

Table 11. Fee-for-Service Behavioral Health Services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS Behavioral Health Services are estimated at 97.0% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Fee-for-Service Behavioral Health Services Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$18,175,906	\$18,732,206	97.0%

Table 12. Comparison of Colorado Medicaid Fee-for-Service Behavioral Health Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$556,300 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 31 procedure codes analyzed in this service grouping, 30 were compared to Medicare (96.8%), and 1 (96110) was compared to other states. Individual rate ratios for FFS Behavioral Health Services were 51.1% - 401.3%.

Access to Care Analysis

The provider participation rate for FFS Behavioral Health Services is 49%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	Utilization (Units)	TPL & Copayments	CO Repriced	Medicare/Other States Repriced	Medicare/Other States Repriced - TPL	CO as a % of Benchmark
1	90833	PSYTX W PT W E/M 30 MIN	\$ 2,991,449	48,271	\$ 12,173	\$ 2,966,166	\$ 3,385,749	\$ 3,373,576	87.9%
2	96133	NRPSYC TST EVAL PHYS/QHP EA	\$ 2,550,220	26,338	\$ 24,528	\$ 2,624,244	\$ 2,648,772	\$ 2,624,244	100.0%
3	90837	PSYTX W PT 60 MINUTES	\$ 2,023,517	16,608	\$ 25,856	\$ 2,164,301	\$ 2,469,510	\$ 2,443,655	88.6%
4	96137	PSYCL/NRPSYC TST PHY/QHP EA	\$ 1,968,512	42,829	\$ 20,761	\$ 2,071,844	\$ 1,734,130	\$ 1,713,369	120.9%
5	96127	BRIEF EMOTIONAL/BEHAV ASSMT	\$ 1,575,164	95,190	\$ 12,738	\$ 453,693	\$ 466,431	\$ 453,693	100.0%
6	90791	PSYCH DIAGNOSTIC EVALUATION	\$ 1,273,263	8,583	\$ 17,008	\$ 1,326,590	\$ 1,518,265	\$ 1,501,256	88.4%
7	96132	NRPSYC TST EVAL PHYS/QHP 1ST	\$ 1,155,444	9,394	\$ 11,773	\$ 1,227,014	\$ 1,238,787	\$ 1,227,014	100.0%
8	96110	DEVELOPMENTAL SCREEN W/SCORE	\$ 641,978	50,782	\$ 5,590	\$ 568,247	\$ 475,827	\$ 470,238	120.8%
9	90836	PSYTX W PT W E/M 45 MIN	\$ 607,372	8,111	\$ 5,279	\$ 627,947	\$ 721,311	\$ 716,032	87.7%
10	90792	PSYCH DIAG EVAL W/MED SRVCS	\$ 597,085	3,679	\$ 13,913	\$ 629,544	\$ 730,245	\$ 716,331	87.9%

Table 13. Top 10 codes utilized for Fee-for-Service Behavioral Health services (FY 2021-22).

HCPF identified two outliers:



Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
96139	PSYCL/NRPSYC TST TECH EA	\$ 62,362	\$ 65,581	\$ 128,341	51.1%
96146	PSYCL/NRPSYC TST AUTO RESULT	\$ 64.19	\$ 67.41	\$ 16.80	401%

Table 14. Outlier for Fee-for-Service Behavioral Health services codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

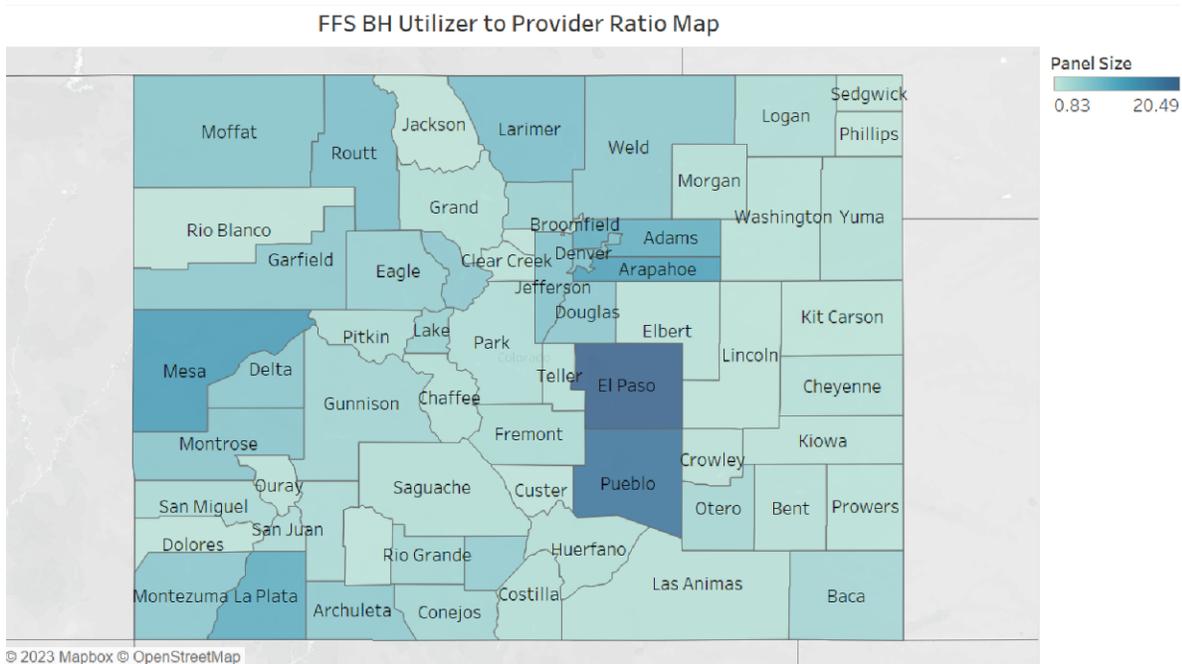


Figure 3. Fee-for-Service Behavioral Health services utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends a language translation modifier for native language speakers for testing codes.
- The MPRRAC recommends reviewing four psychological testing codes (96132, 96133, 96136, 96137) under fee-for-service behavioral health services, as opposed to reviewing under Physician Services category as done previously in the [2022 Medicaid Provider Rate Review Analysis Report](#).
 - Some members support a higher increase above 100%, while others recommend looking at specific codes (96132, 96133, 96136, 96137) to be above 100% in order to alleviate the bottleneck in accessing psychological assessments.

- The anticipated fiscal impact of the MPRRAC’s recommendation is predicted to be \$319,452 total funds, \$159,726 General Fund.

HCPF Recommendations

- HCPF recommends reverting the rates for 2 ASD/Development screening assessment codes (96110 and 96127) to \$18.39 to reflect the rates before the 2019/2022 MPRRAC review plus the 3% across-the-board rate increase applied for FY 2023-24.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$1,664,157 total funds, \$822,078 General Fund.

Policy Justification

Two assessment codes, 96127 and 96110, are used in Colorado for Developmental screenings (96110) and screenings for Autism Spectrum Disorder (ASD) (96127) by primary care physicians. Unfortunately, there are no appropriate Medicare benchmarks for these codes.

HCPF removed these codes from the mental health subset of codes and reviewed them under the physician services codes in 2018. This HCPF specific use of code 96127 is due to the requirement from CMS in 2020 that states were to separate developmental and ASD screenings from each other for mandatory reporting. A 2020 physician and stakeholder workgroup made the recommendations to use these two codes for the required reporting. That change was noticed in the June 2020 HCPF provider bulletin. The use of the codes and the provider bulletin were not reviewed by the MPRRAC committee when reviewing these codes. It is important to note that the rates for these codes were significantly higher than Medicare due to their use in ASD screenings for children, which is not common in Medicare.

These codes provide the same services, just with a different screening tool. The price differential approved by the MPRRAC committee last year is not sustainable for providers. Doctors and therapists now recognize the importance of early intervention when it comes to ASD. Studies suggest early intervention may be even more beneficial. In fact, children who receive intensive therapy early in their life span move higher on the ASD scale and around 20% are able to move out of the spectrum. However, the screening needs to be accomplished to rule children into the appropriate services. If children are not screened for ASD in pediatric and other primary care offices at 9, 18 and 30 months, they will not be able to access early and timely services, leaving the state at risk of needing to provide more treatment to an older child with less benefit. Therefore the codes should be reverted to their prior rates and be priced the same.

Although MPRRAC recommends four codes to be raised to 100% of the benchmark, due to budget restraints HCPF will not be prioritizing funding for this code set due to already being at 97% average. HCPF has previously explored a billing code for translation services, which was ruled out due to cost and therefore not included in HCPF's recommendation. There can be further research exploring this language translation modifier in the future.

Pediatric Behavioral Therapy

Service Description

The pediatric behavioral therapy (PBT) service grouping consists of 6 procedure codes/ modifier combinations. PBT services consist of adaptive behavior treatment services, as well as evaluation and assessment services, for children ages 0-20. PBT services are covered by Early Periodic Screening, Diagnostic, and Treatment (EPSDT). This benefit was created through EPSDT in January 2018, after being removed as a waiver service. These services are provided both in home and clinical settings. PBT services were previously reviewed in the [2020 Medicaid Provider Rate Review Analysis Report](#).

Pediatric Behavioral Therapy Statistics	
Total Adjusted Expenditures FY 2021-22	\$124,914,666
Total Members Utilizing Services in FY 2021-22	5,371
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	18.1%
Total Active Providers FY 2021-22	820
FY 2021-22 Over FY 2020-21 Change in Active Providers	24.1%

Table 15. Pediatric Behavioral Therapy expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for PBT services are estimated at 78.7% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Pediatric Behavioral Therapy Rate Benchmark Comparison		
Colorado Repriced	Other States Repriced	Rate Benchmark Comparison
\$126,433,251	\$160,714,783	78.7%

Table 16. Comparison of Colorado Medicaid Pediatric Behavioral Therapy service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$34,281,532 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 6 procedure codes/ modifier combinations analyzed in this service grouping, 5 were compared to an average of ten other states' (Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, Washington) Medicaid rates with 1 having no comparable rate. Individual rate ratios for PBT services were 36.0% - 84.8%.

Access to Care Analysis

The provider participation rate for PBT services is 85%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. However, there are only six codes under review. During the rate research process, HCPF found that the 97151 + TJ (behavior identification re-assessment code) modifier is specific to Colorado and not used by other states. Therefore, the transformation for the procedure code 97151 without modifier in Colorado specifically was taking the flat rate of \$330.94 (Colorado Medicaid assumes 8 hours total when billing 97151 versus other states' billing per 15-minutes), dividing by 15 minutes to come to the conclusion of the Colorado reimbursement rate of \$10.34 per 15-minute unit, which further translates to \$9.80 per 15-minute unit after living cost adjustment. With this translation established, HCPF removed 97151 + TJ out of the analysis.

Here, the cost of living adjustment index reflected the timeframe of 2023 Q1, which was downloaded from [Missouri Economic Research and Information Center](#) on July 18, 2023. The underlying data source is the [C2ER](#) (Council for Community & Economic Research) Cost of Living Index, which is ranked as one of the most reliable source of region-to-region quarterly comparisons of key consumer costs and is referenced by many academic articles posted on the [Census Academy of United States Census Bureau](#).

HCPF conducted a rate comparison analysis with cost of living adjustment considered. There were 7 states selected for the first round PBT analysis: Florida, Louisiana, North Carolina, Nevada, Texas, Utah, and Washington. Six out of these seven states were

selected for the second round of PBT analysis and Louisiana was removed as the PBT service is under a managed care model. Based on data from Colorado Association for Behavior Analysis (COABA), Nebraska was added to the analysis. In addition, Dr. Peter Walsh (Chief Medicaid Officer at HCPF) recommended Oregon and Gina Robinson (PBT Subject Matter Expert at HCPF) suggested Massachusetts and Michigan. The PBT fee schedule data was not able to be retrieved from Michigan state Medicaid website due to a technical issue, so Michigan was replaced with Maryland. The final states used in the analysis are: Florida, Massachusetts, Maryland, North Carolina, Nebraska, Nevada, Oregon, Texas, Utah, and Washington. HCPF acknowledges that four of the states used in this comparison have a higher cost of living than Colorado (Massachusetts, Maryland, Oregon, Washington), while six have a lower cost of living (North Carolina, Nebraska, Texas, Florida, Nevada, Utah). All of the comparison states have a similar fee-for-service reimbursement model for PBT services in order to maintain comparison integrity.

Living cost adjustment

Procedure Code	Procedure Description	CO HealthFirst	Other States Rates											Percent
			FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other States Average	
97151	BHV ID ASSMT BY PHYS/QHP	\$ 9.80	\$ 18.62	\$ 20.71	\$ 28.00	\$ 27.64	\$ 60.12	\$ 17.31	\$ 16.94	\$ 26.57	\$ 35.73	\$ 14.48	\$ 26.61	37%
97153	ADAPTIVE BEHAVIOR TX BY TECH	\$ 13.64	\$ 11.92	\$ 11.03	\$ 15.70	\$ 18.82	\$ 40.08	\$ 22.53	\$ 11.95	\$ 12.10	\$ 17.66	\$ 9.56	\$ 17.13	80%
97154	GRP ADAPT BHV TX BY TECH	\$ 6.83	\$ 6.43	\$ 9.37	\$ 6.28	\$ 10.28	\$ 40.08	\$ 5.66	\$ 10.39	\$ 2.02		\$ 8.15	\$ 10.96	62%
97155	ADAPT BEHAVIOR TX PHYS/QHP	\$ 21.28	\$ 16.76	\$ 20.71	\$ 28.00	\$ 29.14	\$ 40.08	\$ 22.53	\$ 26.06	\$ 20.39	\$ 35.73	\$ 10.86	\$ 25.03	85%
97158	GRP ADAPT BHV TX BY PHY/QHP	\$ 10.64	\$ 8.39		\$ 7.64		\$ 60.12	\$ 14.10		\$ 3.40		\$ 8.15	\$ 16.97	63%

Table 17. Pediatric behavioral therapy codes compared to 10 other states adjusted for cost of living. (FY 2021-22).

Additionally, HCPF compared rates to Colorado Tricare using current Tricare rates as of July 1, 2023.

Procedure Code	Procedure Description	CO HealthFirst	Colorado Tricare			
			BCBA_D	BCBA	Assistant Behavior Analyst	Behavior Technician
97151	BHV ID ASSMT BY PHYS/QHP	\$ 10.34	\$ 36.73	\$ 36.73	\$ 36.73	
97153	ADAPTIVE BEHAVIOR TX BY TECH	\$ 14.39	\$ 31.25	\$ 31.25	\$ 20.28	\$ 18.15
97154	GRP ADAPT BHV TX BY TECH	\$ 7.21				
97155	ADAPT BEHAVIOR TX PHYS/QHP	\$ 22.45	\$ 33.22	\$ 31.63	\$ 26.36	
97158	GRP ADAPT BHV TX BY PHY/QHP	\$ 11.22	\$ 6.76	\$ 6.76	\$ 6.76	\$ 6.76

Table 18. Pediatric behavioral therapy codes compared to Colorado Tricare rates. (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.



Pediatric Behavioral Therapy Panel Size

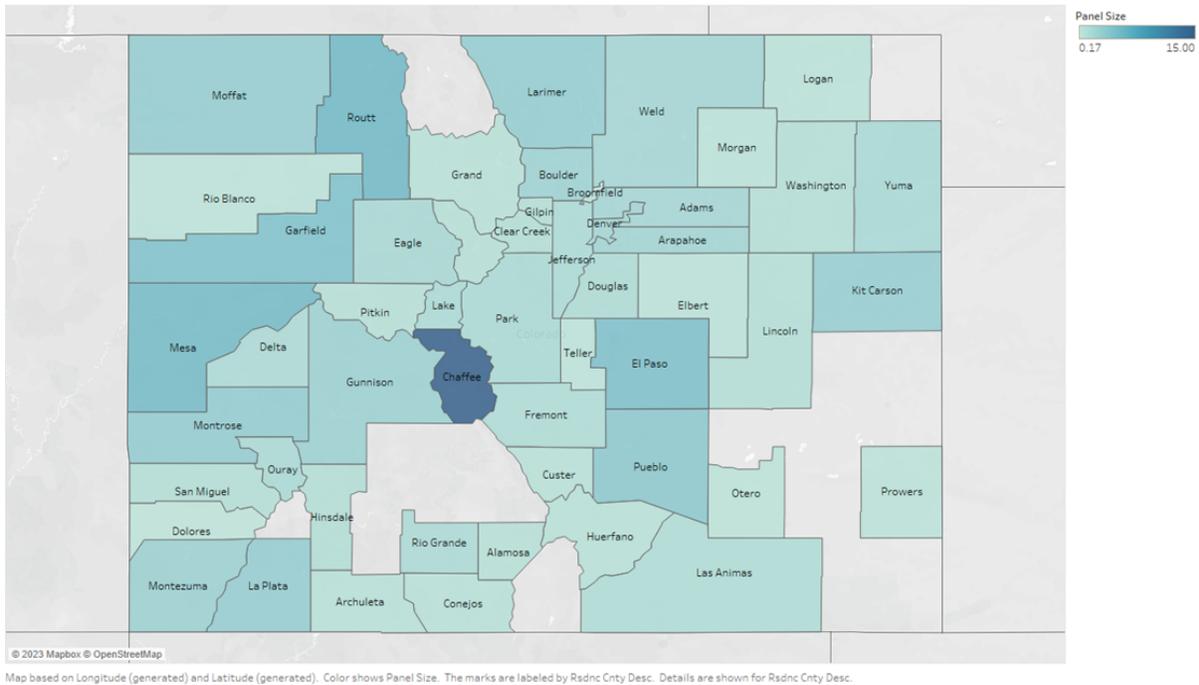


Figure 4. Pediatric behavioral therapy utilizer to provider ratio per county (FY 2021-22)

HCPF recommends removing Nebraska out of the benchmark state list since it is an extreme outlier with higher PBT rates compared to other 9 states (with rates that are 41% - 508% above other states in the benchmark cohort). The rate comparison analysis data is summarized as below after removing Nebraska.

Pediatric Behavioral Therapy Rate Benchmark Comparison		
Colorado Repriced	Other States Repriced	Rate Benchmark Comparison
\$126,433,251	\$139,447,581	90.7%

Table 19. Comparison of Colorado Medicaid Pediatric Behavioral Therapy service payments to those of other payers, expressed as a percentage (FY 2021-22) after removing Nebraska.

Including NE in the analysis brought Colorado's rates as a percentage of the benchmark to 78.7% versus 90.7% without Nebraska in the analysis. Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year's rate increases.

The estimated fiscal impact to Colorado Medicaid would be \$13,019,386 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22 except for 97158 (which is already at 128.5%). Of the 6 procedure codes/modifier combinations



analyzed in this service grouping, 5 were compared to an average of nine other states' (Florida, Massachusetts, Maryland, North Carolina, Nevada, Oregon, Texas, Utah, Washington) Medicaid rates with 1 code having no comparable rate. Individual rate ratios for PBT services, excluding NE, were 41.9% - 128.5%.

The final states used in the analysis are: Florida, Massachusetts, Maryland, North Carolina, Nevada, Oregon, Texas, Utah, and Washington. HCPF acknowledges that four of the states used in this comparison have a higher cost of living than Colorado (Massachusetts, Maryland, Oregon, Washington), while five have a lower cost of living (North Carolina, Texas, Florida, Nevada, Utah). All of the comparison states have a similar fee-for-service reimbursement model for PBT services in order to maintain comparison integrity.

Living cost adjustment

Procedure Code	Procedure Description	CO HealthFirst	Other States Rates										Percent
			FL	MA	MD	NC	NV	OR	TX	UT	WA	Other States Average	
97151	BHV ID ASSMT BY PHYS/QHP	\$ 9.80	\$ 18.62	\$ 20.71	\$ 28.00	\$ 27.64	\$ 17.31	\$ 16.94	\$ 26.57	\$ 35.73	\$ 14.48	\$ 22.89	43%
97153	ADAPTIVE BEHAVIOR TX BY TECH	\$ 13.64	\$ 11.92	\$ 11.03	\$ 15.70	\$ 18.82	\$ 22.53	\$ 11.95	\$ 12.10	\$ 17.66	\$ 9.56	\$ 14.58	94%
97154	GRP ADAPT BHV TX BY TECH	\$ 6.83	\$ 6.43	\$ 9.37	\$ 6.28	\$ 10.28	\$ 5.66	\$ 10.39	\$ 2.02		\$ 8.15	\$ 7.32	93%
97155	ADAPT BEHAVIOR TX PHYS/QHP	\$ 21.28	\$ 16.76	\$ 20.71	\$ 28.00	\$ 29.14	\$ 22.53	\$ 26.06	\$ 20.39	\$ 35.73	\$ 10.86	\$ 23.35	91%
97158	GRP ADAPT BHV TX BY PHY/QHP	\$ 10.64	\$ 8.39		\$ 7.64		\$ 14.10		\$ 3.40		\$ 8.15	\$ 8.33	128%

Table 20. Pediatric behavioral therapy codes compared to 9 other states adjusted for cost of living. (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends increasing PBT rates to 100% of the benchmark of the other ten states and opening up a list of codes that are not currently covered by Colorado Medicaid (such as codes covering parent training).
 - Codes include: 97152, 97156, 97157, 0362T, 0373T
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be \$34,281,532 total funds, \$17,140,766 General Fund.

HCPF Recommendations

- HCPF recommends raising all rates to 100% of the benchmark, excluding Nebraska (90.7%).
 - Nebraska is an extreme outlier with rates that are between 41% - 508% above other states in the benchmark cohort. For example, the Nebraska rate for 97155 per unit is \$36.11 in 2023, which is 41% higher than the average rate of other nine states. Its rate for 97158 per unit is \$54.17, which is 508% higher than the average rate of other nine states.



- Including NE in the analysis brought Colorado's rates as a percentage of the benchmark to 78.7% versus 90.7% without Nebraska in the analysis
 - Because of the impact of Nebraska on the analysis, HCPF left Nebraska out of its benchmark analysis for purposes of its recommendation. This allows HCPF to achieve greater balance across provider types for this year's rate increases.
- HCPF recommends leaving one procedure code (97158) with a benchmark ratio as 128.5% leave at its current rate.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be \$13,019,386 total funds, \$6,509,693 General Fund.

Policy Justification

Given the existing waitlists for services, it is critical for HCPF to establish a reimbursement that supports this specialized workforce and expedites member access to treatment as early as possible. HCPF prioritized 97151 and 97153 to be raised to 100% based on provider feedback that these two codes would make the most impact on PBT technician workforce retention.

HCPF does not have CMS approval to cover parent training and did not receive approval when HCPF originally opened this benefit. HCPF is exploring coverage and payment options at this time and will move forward with the MPRRAC recommendation if and when approval from CMS is received.

Maternity Services

Service Description

The maternity service grouping comprises 50 procedure codes. Maternity services are any medically necessary pregnancy related service that is covered during the obstetrical period, beginning on the date of the initial visit in which pregnancy was confirmed and extending through the end of the postpartum period (generally considered ~60 days following delivery). Most maternity related services are reimbursed utilizing global maternity codes for services (including antepartum care, labor and delivery, and postpartum care) that are provided during the maternity period for uncomplicated pregnancies. Normal antepartum care includes monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. Maternity care for High-Risk Pregnancies and/or Complications of Pregnancy, where patients at risk are seen more frequently during the prenatal period or for other medical/surgical intervention, are usually billed outside of the normal global OB package for these specific services. Any additional medically necessary

visits are usually reported separately with billing codes selected to represent the appropriate level of Evaluation and Management services, as well as billed for separately identified services, such as for other medically necessary laboratory or radiologic tests performed. Maternity services were previously reviewed in the [2018 Medicaid Provider Rate Review Analysis Report](#).

Maternity Services Statistics	
Total Adjusted Expenditures FY 2021-22	\$25,186,891
Total Members Utilizing Services in FY 2021-22	20,138
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	-0.6%
Total Active Providers FY 2021-22	1,382
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.4%

Table 21. Maternity services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for maternity services are estimated at 76.1% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Maternity Services Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$28,378,660	\$37,313,704	76.1%

Table 22. Comparison of Colorado Medicaid Maternity Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$8,935,044 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 50 procedure codes analyzed in this service grouping, 42 were compared to Medicare (84.0%), 2 did not have applicable repricing rates, and 6 did not have valid utilization during FY 2021-22. Individual rate ratios for maternity services were 54.8% - 124.3%.

Access to Care Analysis

The provider participation rate for maternity services is 79%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money. The top 10 codes represent 96.66% of the total dollars spent on maternity services. Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

Rank	Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	59400	OBSTETRICAL CARE	\$ 12,479,676	\$ 13,126,685	\$ 18,926,210	69.4%
2	59510	CESAREAN DELIVERY	\$ 4,647,210	\$ 4,885,956	\$ 6,861,649	71.2%
3	59409	OBSTETRICAL CARE	\$ 2,655,255	\$ 2,808,269	\$ 2,823,494	99.5%
4	59514	CESAREAN DELIVERY ONLY	\$ 1,486,595	\$ 3,246,300	\$ 3,143,400	103.3%
5	59025	FETAL NON-STRESS TEST	\$ 820,602	\$ 1,013,424	\$ 1,246,035	81.3%
6	59410	OBSTETRICAL CARE	\$ 674,149	\$ 708,519	\$ 825,108	85.9%
7	59610	VBAC DELIVERY	\$ 484,273	\$ 509,049	\$ 711,081	71.6%
8	59426	ANTEPARTUM CARE ONLY	\$ 461,080	\$ 484,446	\$ 724,283	66.9%
9	59515	CESAREAN DELIVERY	\$ 390,686	\$ 410,714	\$ 470,089	87.4%
10	59425	ANTEPARTUM CARE ONLY	\$ 244,946	\$ 257,341	\$ 376,207	68.4%

Table 23. Top 10 codes utilized for maternity services (FY 2021-22).

HCPF identified four outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
59130	TREAT ECTOPIC PREGNANCY	\$ 998	\$ 1,048	\$ 1,911	54.8%
59160	D & C AFTER DELIVERY	\$ 36,154	\$ 43,347	\$ 77,443	56.0%
59300	EPISIOTOMY OR VAGINAL REPAIR	\$ 7,242	\$ 8,543	\$ 15,242	56.0%
59430	CARE AFTER DELIVERY	\$ 54,158	\$ 57,383	\$ 98,573	58.2%

Table 24. Outliers for maternity service codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

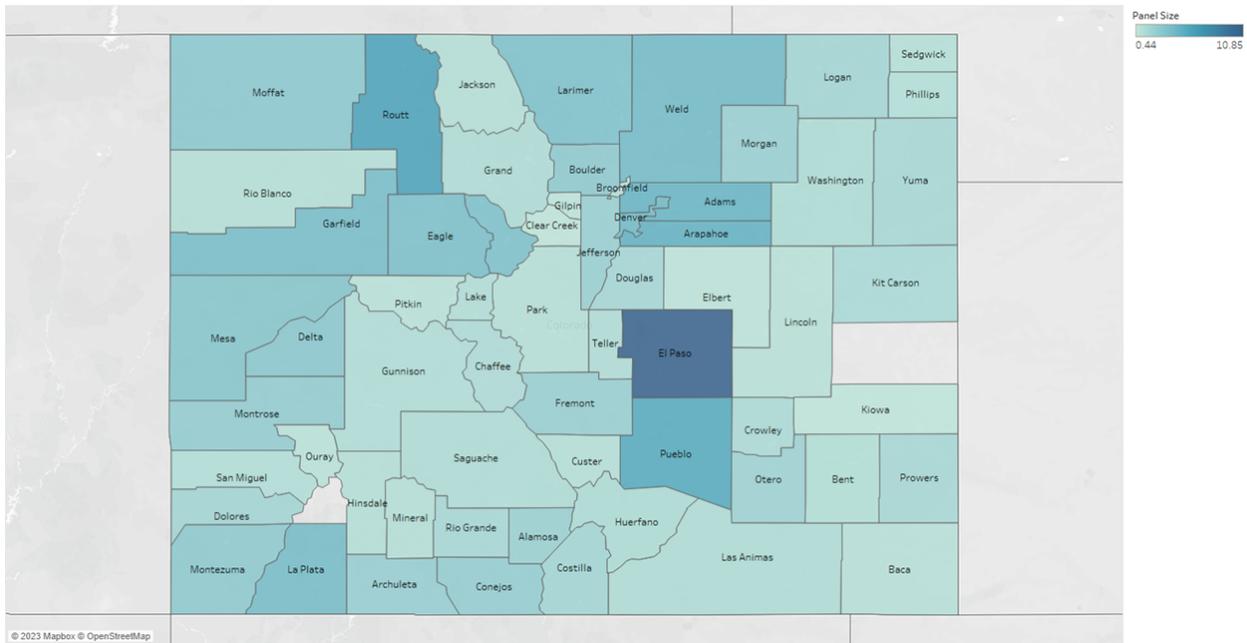


Figure 5. Maternity services utilizer to provider ratio per county (FY 2021-22)

MPPRAC Recommendations

- The MPPRAC recommends an increase of maternity rates to 100% of the benchmark.
- The anticipated fiscal impact of the MPPRAC’s recommendations is predicted to be \$8,942,246 total funds, \$4,471,123 General Fund.

HCPF Recommendations

- HCPF recommends 14 out of 18 general maternity service & care codes increase to 100% of the benchmark (59160, 59300, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 59830).
 - HCPF recommends that the 4 out of 18 general maternity service & care codes that are already above 90% to remain at their current rate (59350, 59409, 59525, 59612).
- HCPF recommends 12 out of 14 pregnancy or non-viable pregnancy codes increase to 80% of the benchmark (59070, 59120, 59121, 59130, 59150, 59001, 59015, 59200, 59812, 59820, 59821, 59870).
 - HCPF recommends that the 2 out of 14 pregnancy or non-viable pregnancy codes that are above 80% to remain at their current rate (59025, 59151).

- HCPF recommends the 10 pregnancy-related codes to remain at their current rate (59000, 59012, 59051, 59140, 59320, 59412, 59414, 59514, 59620, 59871).
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be \$8,494,404 total funds, \$4,247,202 General Fund.

Policy Justification

Recommended increases in rates for codes focused on supporting provider's provision of specific maternity-related services, including prenatal and postpartum care. These services promote improved pregnancy outcomes, reduce maternal morbidity and mortality, and include the service codes for Global (prenatal + Labor & Delivery (L&D) + postpartum care), Partial (L&D & postpartum), and Individual (prenatal & postpartum) maternity related services. Rate increases also focused on specific reproductive care related to labor and delivery.

Abortion Services

Service Description

The abortion service grouping comprises 8 procedure codes. Per Federal/State guidelines, Health First Colorado covers abortion services if one of the three following circumstances exists: 1. A life-endangering condition for the pregnant individual and under situations of, 2. Rape, or 3. Incest. Abortion services have not been formally reviewed as a separate service until this report. Most codes from this category are also used for other reproductive healthcare services, so it has historically been reviewed as a part of maternity services. The following codes (7) had no utilization: 59855, 59841, 59850, 59851, 59852, 59856, 59857. Individual rate ratios for Abortion services were 23.0% - 57.7%.

Access to Care Analysis

The provider participation rate for abortion services is undefined due to utilization. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Due to lack of claims and Personal Health Information (PHI) HCPF was not able to publish an analysis, however, a basic comparison between the Colorado Medicaid Rate (\$204.72) and the Medicare Non-Facility Rate (\$256.69) can be shared.

Based on provider feedback, HCPF selected California (CA), Oregon (OR), and Illinois (IL) as a comparison for the code 59840. HCPF took the average of the 3 states (CA = \$250.85; OR = \$170.60; IL = \$642.18) rates to find a sustainable rate for providers in Colorado (Average = \$354.54).

Based on provider feedback, HCPF selected California (CA) and Illinois (IL) as a comparison for the code 59841. HCPF took the average of the 2 states (CA = \$700.00; IL = \$1,600.00) rates to find a sustainable rate for providers in Colorado (Average = \$1,150).

MPRRAC Recommendations

- The MPRRAC recommends increasing rates closer to other states' Medicaid programs because the rates are only reviewed every three years.
- One suggestion is a targeted rate increase because there is insufficient information due to HIPAA prohibiting the disclosure of codes with less than 30 claims and concerns about how a rate increase may impact other services' rate increases:
 - Concerns about using different states as a benchmark because other factors may not be comparable to Colorado.
 - Concerns that Medicare is not used as the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is N/A.

HCPF Recommendations

- HCPF recommends raising the reimbursement rate for code 59840 (Dilation & Curettage) to \$354.54.
- HCPF recommends raising the reimbursement rate for code 59841 (Dilation & Evacuation) to \$1,150.00.
- The anticipated fiscal impact of HCPF's recommendations is predicted to be \$325 total funds, \$162 General Fund.

Policy Justification

The reimbursement rate for 59840 has never been adjusted. As a covered benefit under certain circumstances, procedure code 59840 should follow the same methodology used to evaluate rates for other covered services. The MPRRAC did not feel

comfortable with giving a definitive recommendation due to HIPAA prohibiting the disclosure of codes with less than 30 claims.

To address MPRRAC’s concerns of using other states as the benchmark rather than Medicare, the majority of Medicare recipients are of an age demographic (older than 65 years old) where abortions are not commonly requested. Therefore, it is the most reasonable comparison to select other state Medicaid programs where abortion coverage is similar to Colorado’s current coverage.

Dental Services

Service Description

The dental service grouping comprises 523 procedure codes (including both reviewed and excluded procedure codes). Historically, Colorado Medicaid covered dental services for children; Colorado Medicaid began covering dental services for adults in 2013. Colorado Medicaid partners with DentaQuest, which operates as an Administrative Services Only organization (ASO), to help members find a dental provider and manage dental benefits. Due to [SB 22-236](#), HCPF was required to update the proposed service categories under review from a five-year cycle to a three-year cycle. Dental services were initially proposed for review in 2024, which would result in this category to go five years without a review, whereas under the new proposed three-year-cycle, all other Services were proposed to be reviewed within three years of their last review. After hearing from public stakeholders and providers within this service category, HCPF decided to add dental services as a partial review due to lack of data and resources, while maintaining a full review in 2024 as scheduled.

Dental services were previously reviewed in the [2018 Medicaid Provider Rate Review Analysis Report](#).

Dental Services Statistics	
Total Adjusted Expenditures FY 2021-22	\$276,056,155
Total Members Utilizing Services in FY 2021-22	514,162
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	7.3%
Total Active Providers FY 2021-22	1,785
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.5%

Table 25. Dental Services expenditure and utilization data.



Rate Comparison Analysis

On average, Colorado Medicaid payments for dental services are estimated at 49.8% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below. The benchmark data is American Dental Association (ADA) 2022 survey data. Based on the random sample data from a nationwide group of dentists, the ADA survey data provides the national average dental fees for more than 200 commonly used dental procedure codes.

Dental Services Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$301,745,345	\$606,171,602	49.8%

Table 26. Comparison of Colorado Dental Service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$304,426,257 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 523 procedure codes analyzed in this service grouping, 151 were compared to the ADA Survey (28.9%), 199 did not have applicable repricing rates, and 173 did not have valid utilization during FY 2021-22. Individual rate ratios for dental services were 10.8% - 135.9%.

Access to Care Analysis

The provider participation rate for dental services is undefined. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

The MPRRAC requested to view the top 10 codes utilized in this service category to show the driving force behind which codes are costing each service category the most money.

Rank	Procedure code	Procedure Description	Paid Amount	Utilization (Units)	TPL & Copayments	CO Repriced	ADA Repriced	ADA Repriced - TPL	CO as a % of Benchmark
1	D2392	Resin Based Comp Two Surfaces Posterior	\$ 23,205,885	182,375	\$ 319,858	\$ 24,816,889	\$ 44,222,290	\$ 43,902,432	56.5%
2	D2391	Resin Based Comp One Surface Posterior	\$ 12,844,085	128,419	\$ 134,615	\$ 13,716,658	\$ 24,526,745	\$ 24,392,130	56.2%
3	D7140	Extraction Erupted Tooth/Exposed Root	\$ 12,209,393	125,216	\$ 143,268	\$ 13,246,079	\$ 23,769,753	\$ 23,626,486	56.1%
4	D2740	Crown, Porcelain/Ceramic substrate	\$ 10,387,589	23,870	\$ 159,003	\$ 11,361,136	\$ 28,956,220	\$ 28,797,216	39.5%
5	D2393	Resin Base Comp Three Surface Posterior	\$ 10,321,694	66,588	\$ 138,236	\$ 11,116,468	\$ 19,631,474	\$ 19,493,238	57.0%
6	D2930	Prefab Stainless Steel Crown Primary	\$ 10,127,154	83,285	\$ 71,702	\$ 10,906,927	\$ 23,616,295	\$ 23,544,592	46.3%
7	D1110	Prophylaxis Adult	\$ 10,096,813	245,915	\$ 8,079	\$ 10,622,826	\$ 23,976,713	\$ 23,968,633	44.3%
8	D8090	Comprehen Ortho Adult Dentition	\$ 9,642,811	3,685	\$ 18,830	\$ 9,794,436	\$ 19,994,921	\$ 19,976,091	49.0%
9	D0120	Periodic oral evaluation	\$ 9,425,146	422,434	\$ 4,565	\$ 9,947,980	\$ 23,145,159	\$ 23,140,594	43.0%
10	D7240	Removal Impacted Tooth Complete Bony	\$ 8,865,658	34,162	\$ 130,656	\$ 9,788,964	\$ 17,264,792	\$ 17,134,136	57.1%

Table 27. Top 10 codes utilized for dental services (FY 2021-22).

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on. The overall benchmark ratio for dental is only 49.8%, so the majority of codes fall under 60% of the benchmark. We found 134 out of 151 dental codes that can be identified as outliers (above 140% or below 60%), however when changing the criteria codes below 40% of the benchmark, we found 17 out of 151 as outliers.

HCPF identified 17 outliers:

Procedure code	Procedure Description	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
D1354	Interim Caries Arresting Medicament Appli	\$ 99,938	\$ 106,957	\$ 992,290	10.8%
D0190	Screening of a patient	\$ 82,131	\$ 87,155	\$ 304,027	28.7%
D1208	Topical application of fluoride - excluding	\$ 389,745	\$ 408,527	\$ 1,356,921	30.1%
D4212	Gingivectomy/plasty rest	\$ 6,774	\$ 7,118	\$ 22,161	32.1%
D5650	Add Tooth to Existing Partial Denture	\$ 69,250	\$ 73,595	\$ 220,533	33.4%
D3222	Part pulp for apexogenesis	\$ 4,101	\$ 4,197	\$ 11,925	35.2%
D2799	Provisional crown	\$ 481	\$ 505	\$ 1,427	35.4%
D7111	Extraction, coronal remnants	\$ 410,018	\$ 433,434	\$ 1,202,008	36.1%
D1352	Prev resin rest, perm tooth	\$ 46,819	\$ 49,612	\$ 135,976	36.5%
D2783	Crown 3/4 Porcelain/Ceramic	\$ 4,334	\$ 5,064	\$ 13,652	37.1%
D9223	Deep sedation/general anesthesia – each	\$ 5,906,327	\$ 7,281,990	\$ 19,435,698	37.5%
D2929	Prefabricated Porcelain/Ceramic Crown-P	\$ 291,485	\$ 321,856	\$ 844,982	38.1%
D2790	Crown Full Cast High Noble Metal	\$ 19,753	\$ 23,856	\$ 61,769	38.6%
D7450	Remov Ben Odontogenic Cyst to 1.25 cm	\$ 3,048	\$ 3,206	\$ 8,205	39.1%
D2740	Crown, Porcelain/Ceramic substrate	\$ 10,387,589	\$ 11,361,136	\$ 28,797,216	39.5%
D9420	Hospital/ASC call	\$ 584,377	\$ 621,016	\$ 1,559,352	39.8%
D2750	Crown Porcelain High Noble Metal	\$ 1,181,149	\$ 1,303,071	\$ 3,264,949	39.9%

Table 28. Outliers for dental services codes (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.



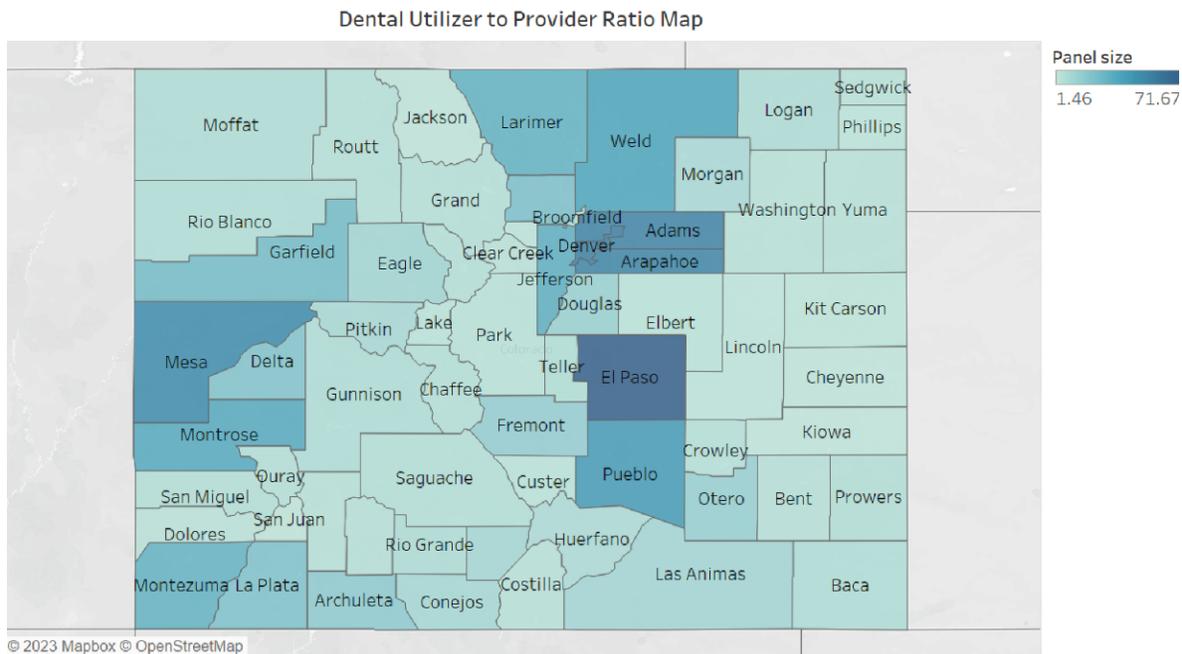


Figure 6. Dental services utilizer to provider ratio per county (FY 2021-22)

MPRRAC Recommendations

- The MPRRAC recommends that the 24 codes that the Colorado Dental Association submitted to be increased to 100% of the benchmark to have the most immediate impact on the dental community.
- The 24 identified codes are: D0120, D0140, D0150, D1110, D1120, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930, D3310, D3320, D3330, D3346, D3347, D3348, D4341, D4342, and D4910.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be \$104,138,137 total funds, \$19,015,624 General Fund.

HCPF Recommendations

- HCPF recommends increasing preventative dental codes (D1110, D1120), endodontic codes (D3310, D3320, D3330, D3346, D3347, D3348) and periodontic codes (D4341, D4342 and D4910) to the 100% benchmark. This aligns with incentivizing dental prevention and efforts to improve member access and equity to oral health care.
- HCPF recommends the remaining thirteen codes (D0120, D0140, D0150, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2930) for diagnostic services to increase to 70% of the benchmark at this time.

- HCPF recommends raising four additional preventative procedure codes: D1206, D1351, D1352, D1354 (3 codes are for sealants and 1 is for silver diamine fluoride to arrest decay) to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$85,620,023 total funds, \$15,634,217 General Fund.

Policy Justification

Effective July 1, 2023 the \$1500 benefit maximum for the adult dental benefit was removed, and there is currently no dollar limit to the amount of services that Adult members and Intellectual and Developmental Disabilities (IDD) members can receive under the state dental plan. The Dental team took into consideration 3 aspects of the fabrication of crowns, dentures, and/or partials needed to complete root canal treatment: the Provider network, lab (overhead) costs, and time (multiple appointments), which led to the recommendation to raise these codes to 100% of the benchmark. HCPF agreed with MPRAAC on 11 of the 24 to be increased to 100% of the benchmark. The remaining 13 of the 24, HCPF recommends an increase to 70% of the benchmark (correction). These preventative, diagnostic, periodontal (exams, and cleanings, deep cleanings) codes are a service that are covered multiple times per year. This allows for HCPF to review and recommend an increase to 173 CDT codes.

Surgeries

The seven sub-categories of surgeries that are being examined in this report are as follows:

- Digestive System
- Musculoskeletal System
- Cardiovascular System
- Respiratory System
- Integumentary System
- Eye and Auditory System
- Other Surgeries

Surgeries Statistics	
Total Adjusted Expenditures FY 2021-22	\$108,963,932
Total Members Utilizing Services in FY 2021-22	235,744
FY 2021-22 Over FY 2020-21 Change in Members Utilizing Services	-3.1%
Total Active Providers FY 2021-22	14,943
FY 2021-22 Over FY 2020-21 Change in Active Providers	3.4%



Table 29. Surgeries total expenditure and utilization data (FY 2021-22).

The surgeries service grouping comprises 5,713 procedure codes. Of the 5,173 procedure codes analyzed in this service grouping, 3,948 were compared to Medicare (76.3%), and 102 did not have applicable repricing rates, and 1,663 did not have valid utilization in FY 2021-22.

The provider participation rate for all surgery categories is 62%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers. The MPRRAC requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - All Surgeries

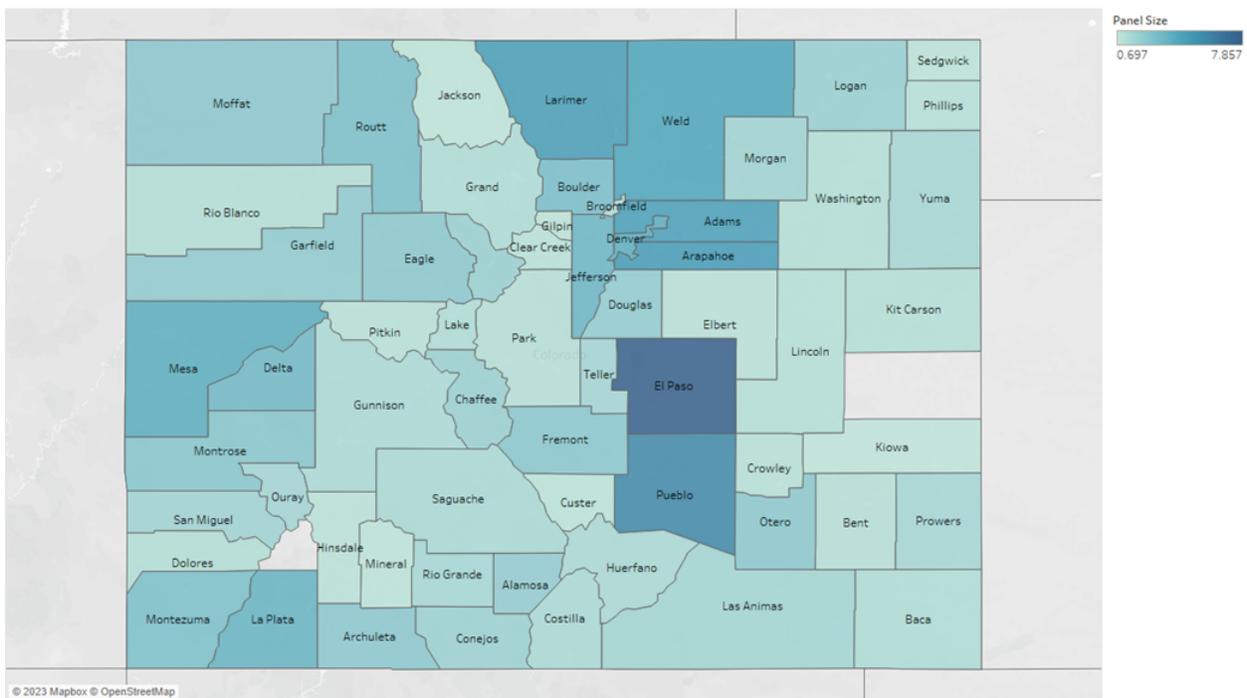


Figure 7. Surgeries (all service categories) utilizer to provider ratio per county (FY 2021-22)

HCPF identified 1,806 outliers for all surgery categories. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.



Figure 8. Outliers for surgeries (all service categories) over 140% (FY 2021-22).

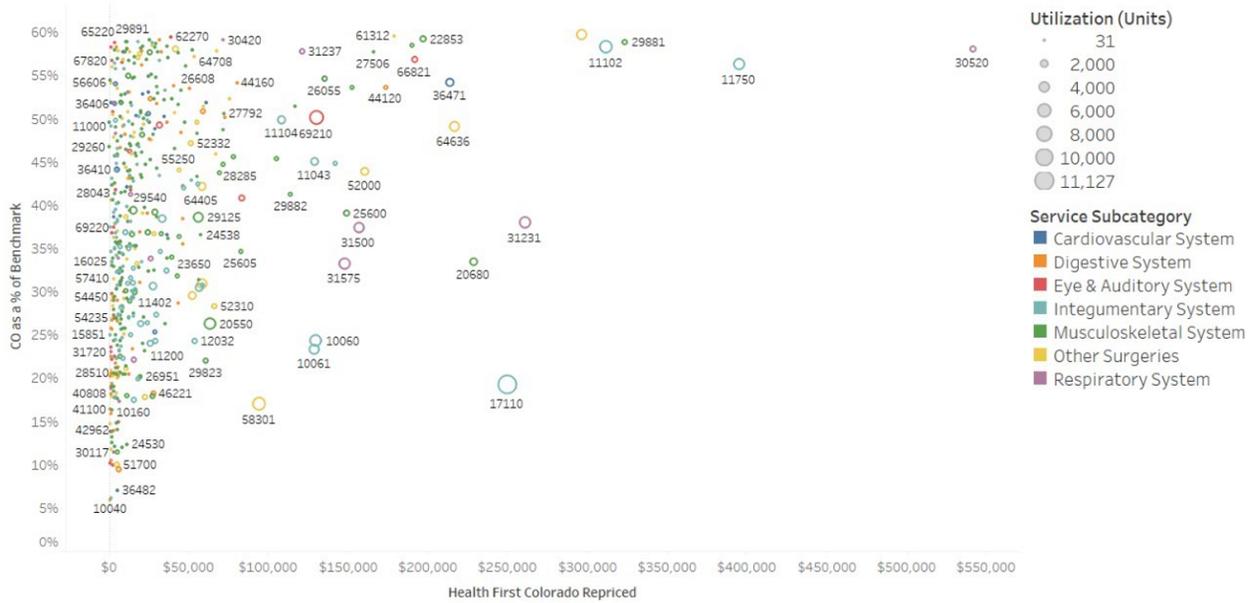


Figure 9. Outliers for surgeries (all service categories) under 60% (FY 2021-22).

The top ten codes for all surgery categories represent 19% of the total dollars spent on surgeries and are listed below:



Rank	Procedure code	Procedure Description	Service Subcategory	Paid Amount	CO Repriced	Medicare Repriced	CO as a % of Benchmark
1	36475	ENDOVENOUS RF 1ST VEIN	Cardiovascular System	\$ 3,509,446	\$ 3,663,773	\$ 2,315,475	158.2%
2	43239	EGD BIOPSY SINGLE/MULTIPLE	Digestive System	\$ 3,135,472	\$ 2,804,738	\$ 2,240,528	125.2%
3	66984	XCAPSL CTRC RMVL W/O ECP	Eye & Auditory System	\$ 2,782,361	\$ 3,575,324	\$ 3,233,924	110.6%
4	45380	COLONOSCOPY AND BIOPSY	Digestive System	\$ 2,183,223	\$ 2,162,143	\$ 1,764,051	122.6%
5	45385	COLONOSCOPY W/LESION REMOVAL	Digestive System	\$ 2,085,520	\$ 2,059,813	\$ 1,732,628	118.9%
6	45378	DIAGNOSTIC COLONOSCOPY	Digestive System	\$ 1,653,479	\$ 1,549,085	\$ 1,221,953	126.8%
7	27447	TOTAL KNEE ARTHROPLASTY	Musculoskeletal System	\$ 1,340,800	\$ 1,706,191	\$ 1,481,587	115.2%
8	64483	NJX AA&/STRD TFRM EPI L/S 1	Other Surgeries	\$ 1,293,459	\$ 1,093,488	\$ 1,063,686	102.8%
9	49083	ABD PARACENTESIS W/IMAGING	Digestive System	\$ 1,239,134	\$ 1,317,225	\$ 531,586	247.8%
10	47562	LAPAROSCOPIC CHOLECYSTECTOMY	Digestive System	\$ 1,200,953	\$ 1,193,922	\$ 1,401,313	85.2%

Table 30. Top 10 codes utilized for surgeries (all service categories) (FY 2021-22).

Surgeries - Digestive System

Service Description

The digestive system surgery service grouping comprises 884 procedure codes (including both reviewed and excluded procedure codes). Digestive system surgery services involve surgical and diagnostic procedures extending from where the food enters the body to where it leaves. Digestive System Surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for the digestive system surgery services are estimated at 96.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Digestive System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$21,656,071	\$22,469,116	96.4%

Table 31. Comparison of Colorado Medicaid digestive system surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$813,045 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 884 procedure codes analyzed in this service grouping, 597 were compared to Medicare (67.5%), 27 did not have applicable repricing rates, and 260 did not have any valid utilization during FY 2021-22. Individual rate ratios for Digestive System Surgery services were 6.0% - 1453.2%.



Access to Care Analysis

The provider participation rate for digestive system surgery services is 46%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 315 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Digestive Surgery Outliers over 140%

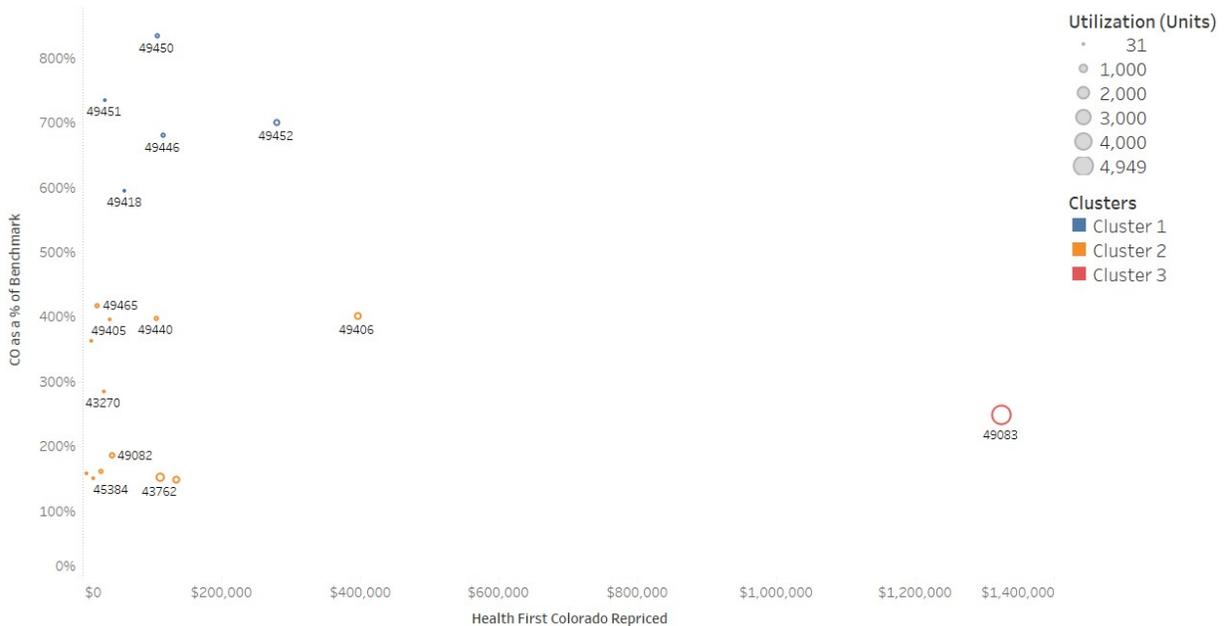


Figure 10. Outliers for digestive surgeries over 140% (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends keeping preventative surgery codes at 100% of the benchmark.
 - Preventative surgery codes include:
 - 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45390, 45391, 45392, 45393, 45395, 45397, 45398.
- For all other codes, rebalance to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be (\$1,447,136) total funds, (\$423,461) General Fund.

HCPF Recommendations

- HCPF recommends raising preventative surgery codes to 100% of the benchmark and keeping any preventative surgery codes over 100% at their current rate.
 - Preventative surgery codes include: 45378 through 45398
- HCPF recommends a rebalance of all other codes below 70% of the benchmark to be increased to 70%, and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be (\$1,165,252) total funds, (\$340,976) General Fund.

Policy Justification

HCPF's recommendation aligns with the MPRRAC recommendations and prioritizes preventative surgery codes. Rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Musculoskeletal System

Service Description

The musculoskeletal system surgery service grouping comprises 1,634 procedure codes (including both reviewed and excluded procedure codes). Musculoskeletal system surgery services involve procedures done to the locomotor system, such as spine fusions, arthroscopy, and arthroplasty. Musculoskeletal system surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for musculoskeletal system surgery services are estimated at 66.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Musculoskeletal System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$24,538,187	\$36,927,306	66.4%

Table 32. Comparison of Colorado Medicaid Musculoskeletal System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$12,389,119 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 1,634 procedure codes analyzed in this service grouping, 1,240 were compared to Medicare (75.9%), 20 did not have applicable repricing rates, and 374 did not have valid utilization during FY 2021-22. Individual rate ratios for Musculoskeletal System Surgery services were 6.2% - 1734.1%.

Access to Care Analysis

The provider participation rate for musculoskeletal system surgery services is 53%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 708 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - Musculoskeletal Systems

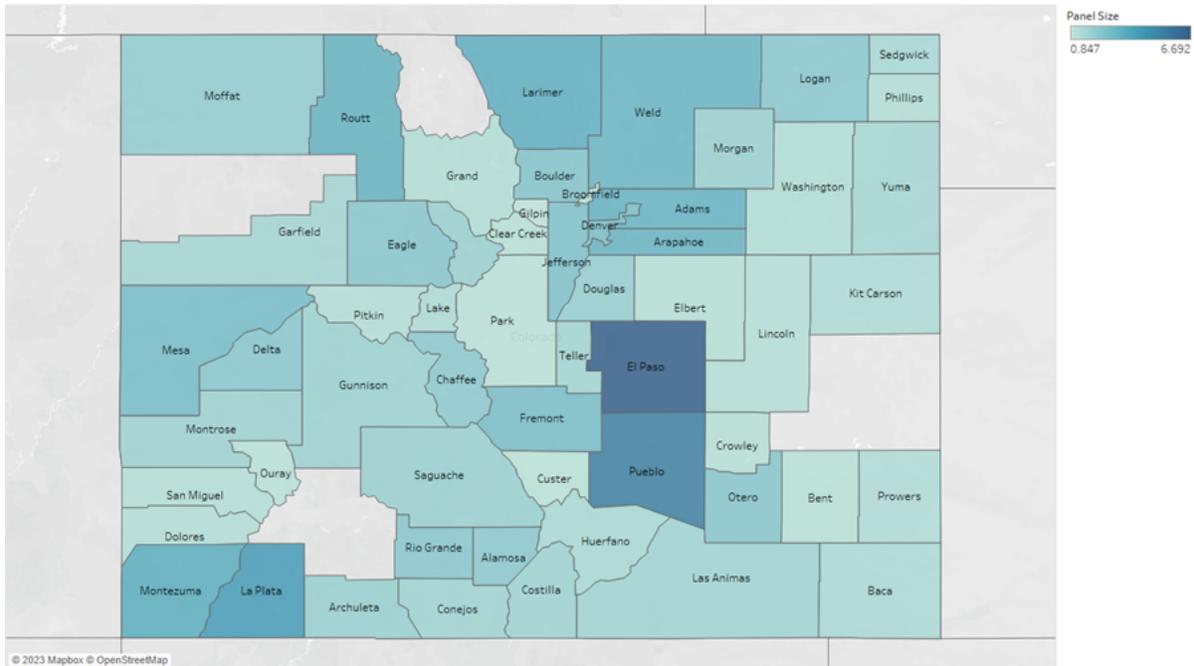


Figure 15. Musculoskeletal surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be \$5,003,658 total funds, \$1,464,171 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$3,732,671 total funds, \$1,092,254 General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The musculoskeletal system surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Cardiovascular System

Service Description

The cardiovascular system surgery service grouping comprises 767 procedure codes. Cardiovascular system surgery services involve procedures related to the heart, veins, and arteries. Cardiovascular system surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for cardiovascular system surgery services are estimated at 162.4% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Cardiovascular System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$17,675,644	\$10,881,937	162.4%

Table 33. Comparison of Colorado Medicaid Cardiovascular System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be (\$6,793,706) total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 767 procedure codes analyzed in this service grouping, 446 were compared to Medicare (58.1%), 12 did not have applicable repricing rates, and 309 did not have valid utilization during FY 2021-22. Individual rate ratios for Cardiovascular System Surgery services were 5.6% - 1302.4%.

The repricing methodology of cardiovascular surgery service which MPRRAC committee's recommendations are based is consistent with other surgeries services, i.e., different Medicare fees were used depending on whether the encounter was done at a facility or non-facility, based on the place of service code in the data. These repricing amounts and benchmark ratio are listed in the Table 31 above. However, the department recommended applying the Medicare non-facility fee schedule only to cardiovascular surgery service. Based on the Medicare non-facility

fee schedule, the benchmark ratio of cardiovascular system surgery services decreased from 162.4% to 74.8%. The CO repriced amount is \$17,683,989 and the Medicare repriced is \$23,656,358. The ratio range for this new repricing method is 2.2% - 162.9%. The reason why the Medicare repricing methodology was changed for the cardiovascular system surgery services was because this category has the lowest provider participation ratio among all surgery services (40%).

Access to Care Analysis

The provider participation rate for cardiovascular system surgery services is 40%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 123 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Cardiovascular Surgery Outliers over 140%

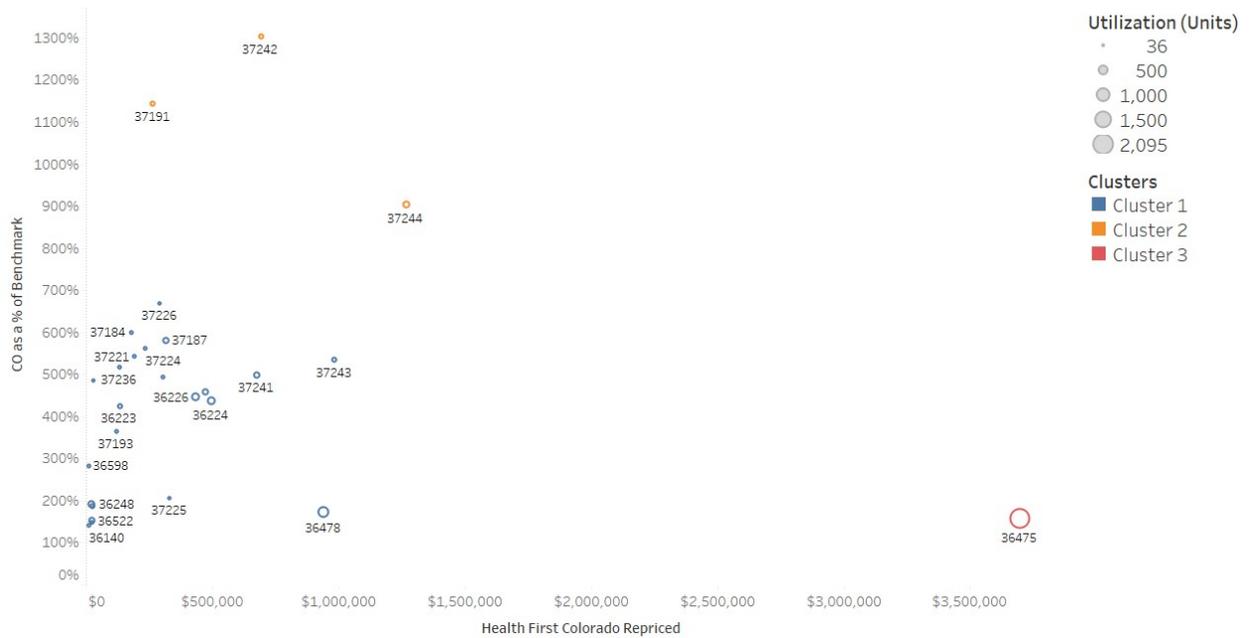


Figure 16. Outliers for cardiovascular surgeries over 140% (FY 2021-22).

Cardiovascular Surgery Outliers Under 60%



Figure 17. Outliers for cardiovascular surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.



Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Respiratory System

Service Description

The respiratory system surgery service grouping comprises 310 procedure codes. Respiratory system surgery services involve procedures related to the diagnostic evaluation and invasive surgeries of the nose, trachea, bronchi, lungs, and pleura. Respiratory system surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for respiratory system surgery services are estimated at 82.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Respiratory System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$5,026,476	\$6,092,153	82.5%

Table 34. Comparison of Colorado Medicaid Respiratory System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$1,065,677 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 310 procedure codes analyzed in this service grouping, 202 were compared to Medicare (65.2%), 6 did not have applicable repricing rates, and 102 did not have valid utilization for FY 2021-22. Individual rate ratios for Respiratory System Surgery services were 6.4% - 823.3%.

Access to Care Analysis

The provider participation rate for respiratory system surgery services is 51%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.



Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 88 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Respiratory Surgery Outliers over 140%



Figure 19. Outliers for respiratory surgeries over 140% (FY 2021-22).

Respiratory Surgery Outliers Under 60%



Figure 20. Outliers for respiratory surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - Respiratory Systems

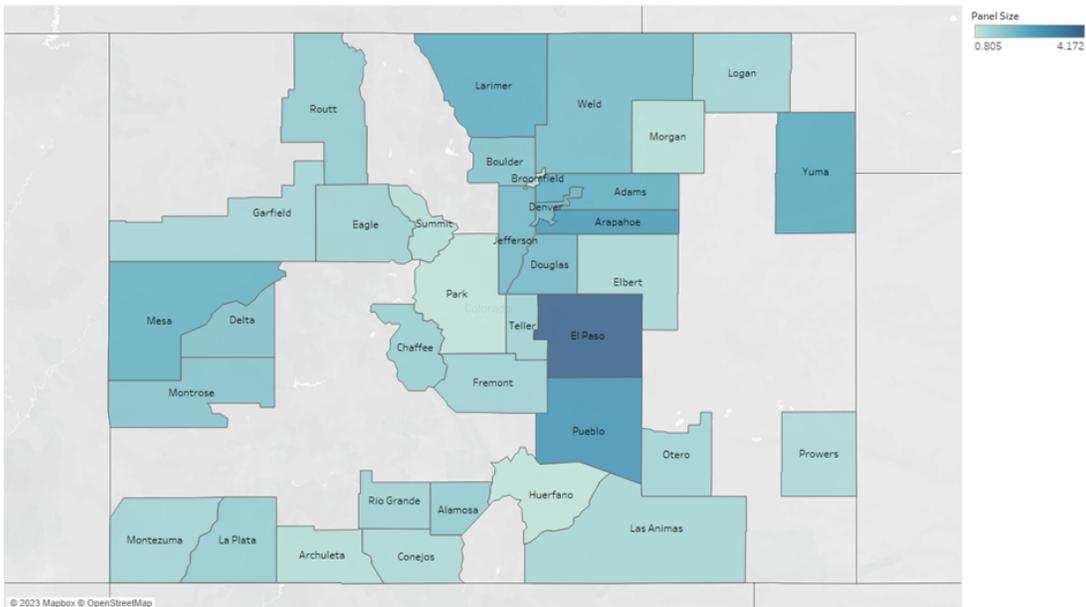


Figure 21. Respiratory surgeries utilizer to provider ratio per county (FY 2021-22).



MPRRAC Recommendations

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be \$180,879 total funds, \$52,929 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be (\$223,909) total funds, (\$65,520) General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The respiratory system surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department’s recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Integumentary System

Service Description

The integumentary system surgery service grouping comprises 414 procedure codes. Integumentary system surgery services involve procedures of the skin and breast. Integumentary system surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for integumentary system surgery services are estimated at 63.5% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Integumentary System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$10,310,353	\$16,229,309	63.5%



Table 35. Comparison of Colorado Medicaid Integumentary System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$5,918,956 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 414 procedure codes analyzed in this service grouping, 330 were compared to Medicare (79.7%), 7 did not have applicable repricing rates, and 76 did not have valid utilization during FY 2021-22. Individual rate ratios for Integumentary System Surgery services were 4.7% - 470.9%.

Access to Care Analysis

The provider participation rate for integumentary system surgery services is 60%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 171 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

Integumentary Surgery Outliers over 140%



Figure 22. Outliers for integumentary surgeries over 140% (FY 2021-22).

Integumentary Surgery Outliers Under 60%



Figure 23. Outliers for integumentary surgeries under 60% (FY 2021-22).



The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - Integumentary Systems

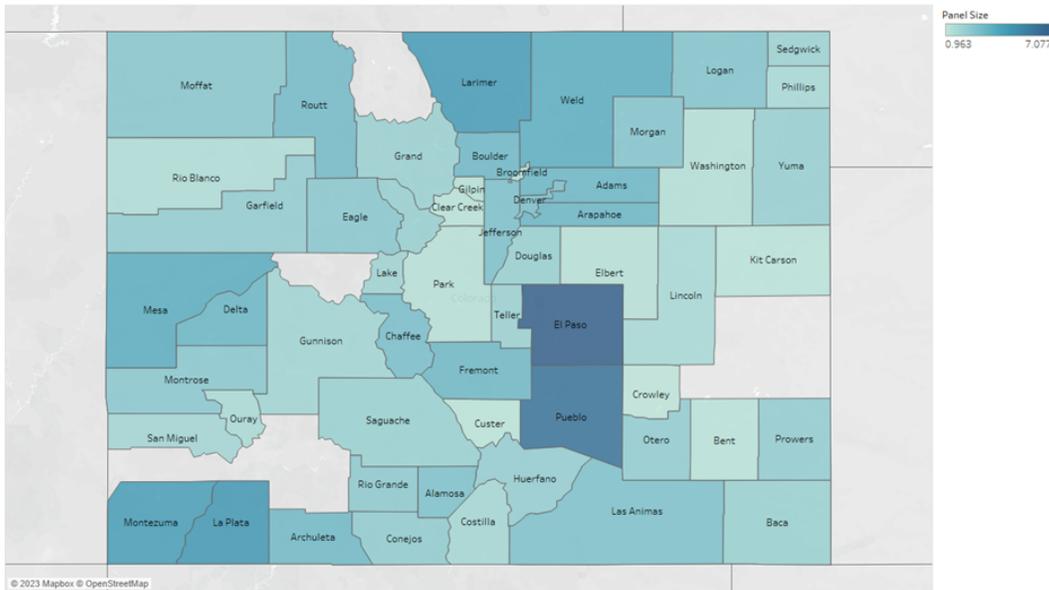


Figure 24. Integumentary surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be \$3,216,801 total funds, \$941,300 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
 - HCPF recommends 1 preventative code (17380) to increase to 100% of the benchmark.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$2,081,628 total funds, \$609,126 General Fund.

Policy Justification

Since HCPF’s recommendation is to prioritize preventative surgery codes. In addition to recommending rebalancing codes above and below benchmark rates to fit within budget restrictions and provide a more equitable distribution of available funding, HCPF recommends increasing one preventative code to 100%.

Surgeries - Eye and Auditory System

Service Description

The eye and auditory system surgery service grouping comprises 370 procedure codes. Eye and auditory systems surgery services involve surgeries pertaining to the eye, including the ocular muscles and eyelids, and ears. Eye and auditory system surgery services were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for eye and auditory system surgery services are estimated at 95.0% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Eye and Auditory System Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$8,529,687	\$8,975,288	95.0%

Table 36. Comparison of Colorado Medicaid Eye and Auditory System Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$445,601 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 370 procedure codes analyzed in this service grouping, 249 were compared to Medicare (67.3%), 9 did not have applicable repricing rates, and 112 did not have valid utilization during FY 2021-22. Individual rate ratios for eye and auditory system surgery services were 7.8% - 653.8%.

Access to Care Analysis

The provider participation rate for eye and auditory system surgery services is 50%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.



Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 103 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.

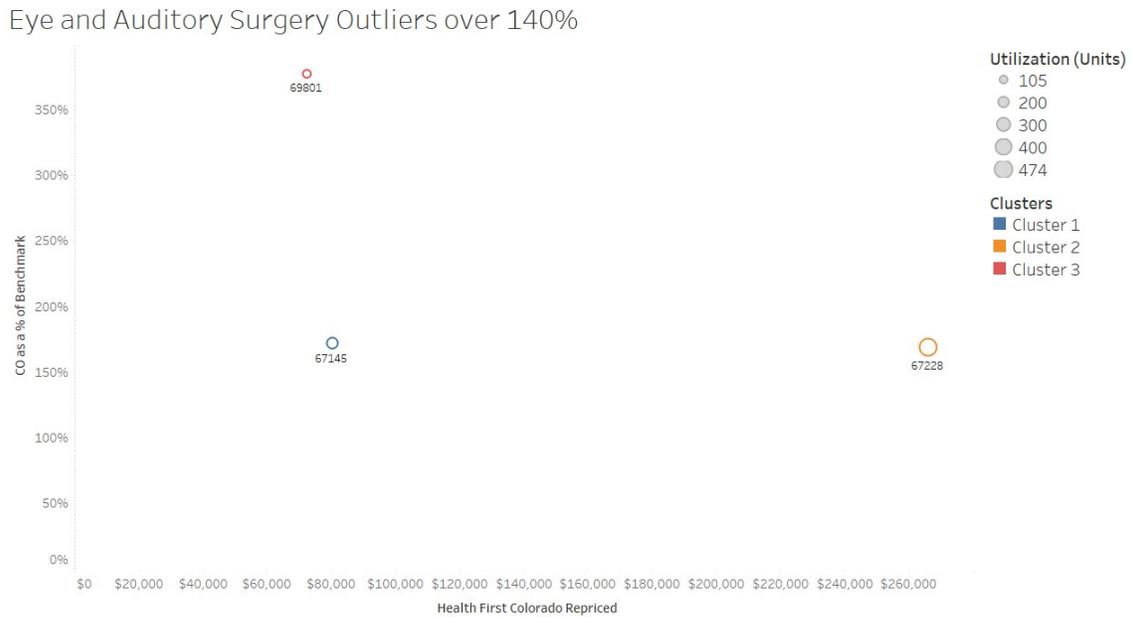


Figure 25. Outliers for eye and auditory surgeries over 140% (FY 2021-22).

Eye and Auditory Surgery Outliers Under 60%



Figure 26. Outliers for eye and auditory surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.

Surgery Panel Size - Eye and Auditory Systems

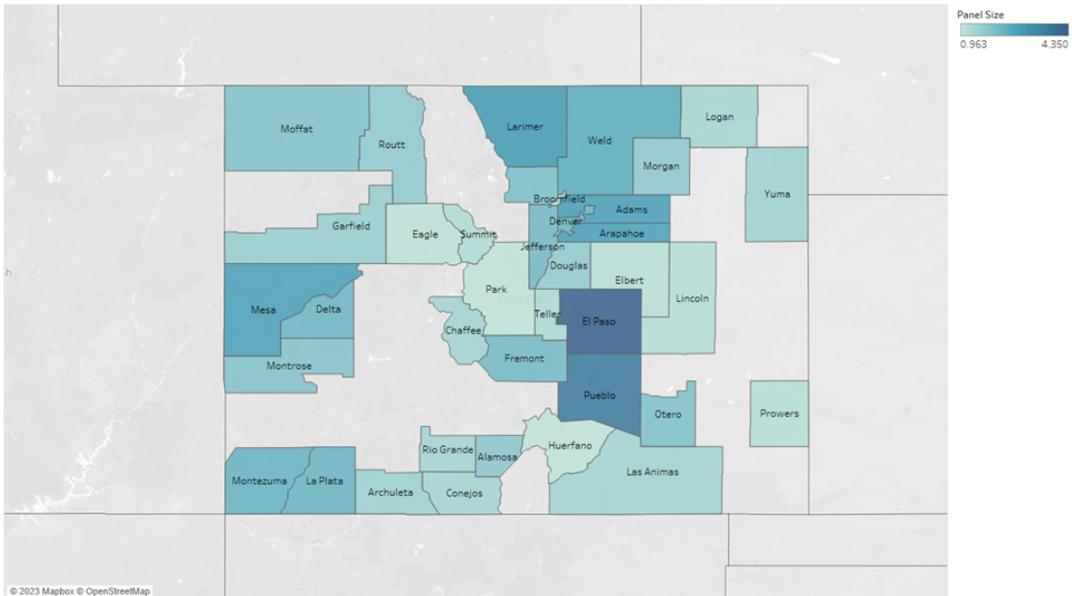


Figure 27. Eye and auditory surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be (\$176,581) total funds, (\$51,671) General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF's recommendations is predicted to be (\$383,945) total funds, (\$112,350) General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The eye and auditory surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Surgeries - Other

Service Description

The other surgery service grouping comprises 1334 procedure codes. This category includes procedures which are considered surgeries but are not included in any of the other surgical categories covered in this report. Services under "other surgeries" are as follows: endocrine system, female genital system, male genital system, intersex surgery, and urinary system. These surgery categories have been added to the rate review cycle since surgeries were previously reviewed in the [2017 Medicaid Provider Rate Review Analysis Report](#).

Rate Comparison Analysis

On average, Colorado Medicaid payments for other surgery services are estimated at 78.2% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Other Surgery Rate Benchmark Comparison		
Colorado Repriced	Medicare Repriced	Rate Benchmark Comparison
\$21,227,515	\$27,145,528	78.2%

Table 37. Comparison of Colorado Medicaid Other Surgery service payments to those of other payers, expressed as a percentage (FY 2021-22).

The estimated fiscal impact to Colorado Medicaid would be \$5,918,013 total funds if Colorado had reimbursed at 100% of the benchmark in FY 2021-22. Of the 1334 procedure codes analyzed in this service grouping, 883 were compared to Medicare (66.2%), 21 did not have applicable repricing rates, and 430 did not have valid utilization during FY 2021-22. Individual rate ratios for Other Surgery services were 2.5% - 1335.2%.

Access to Care Analysis

The provider participation rate for other surgery services is 54%. The provider participation ratio identifies the percentage of providers in Colorado that serve Medicaid patients relative to all state providers.

Stakeholder Feedback

See [Appendix D](#) for Stakeholder Feedback.

Additional Research

Any code's rates above 140% and below 60% are shown as outliers which may indicate which codes HCPF is vastly over or underspending on.

HCPF identified 298 outliers. The cluster graphs below depict all outliers above 140% and below 60%, which may indicate which codes HCPF is vastly over or underspending on.



Other Surgery Outliers over 140%



Figure 28. Outliers for other surgeries over 140% (FY 2021-22).

Other Surgery Outliers Under 60%



Figure 29. Outliers for other surgeries under 60% (FY 2021-22).

The MPRRAC also requested a visual to represent the utilizer to provider ratio, as shown below. Darker colors represent heavier utilization, on the contrary, lighter colors represent less utilization.



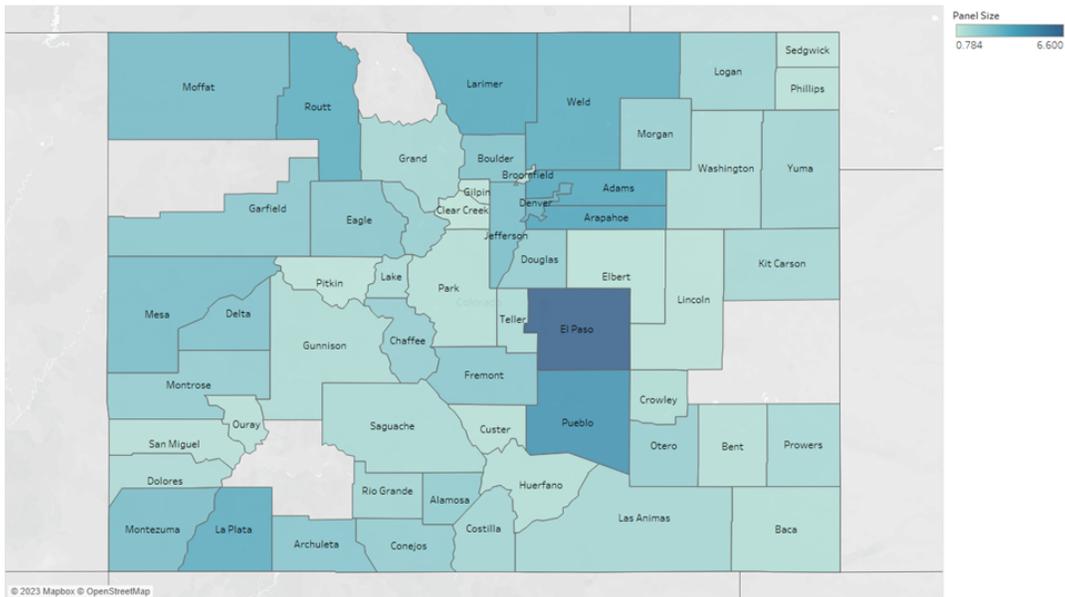


Figure 30. Other surgeries utilizer to provider ratio per county (FY 2021-22).

MPRRAC Recommendations

- The MPRRAC recommends a rebalance of codes below the 80% benchmark to be increased to 80% and codes above 100% of the benchmark to be reduced to 100% (correction).
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be \$1,809,649 total funds, \$529,540 General Fund.

HCPF Recommendations

- HCPF recommends a rebalance of codes below the 70% benchmark to be increased to 70% and codes above 100% of the benchmark to be reduced to 100%.
- The anticipated fiscal impact of the HCPF’s recommendations is predicted to be \$505,358 total funds, \$147,878 General Fund.

Policy Justification

For the overall surgery category, HCPF is prioritizing preventative surgery codes. The other surgery category does not have preventative codes; however, if funding allows, rebalancing codes above and below benchmark rates allows the Department's

recommendation to fit within budget restrictions and provides a more equitable distribution of available funding.

Co-Surgery

HCPF reviewed its co-surgery policy in response to provider feedback regarding reimbursement for certain procedures when performed as co-surgeries. Providers expressed concern that the limited scope of co-surgery reimbursement does not allow the flexibility for two surgeons to collaborate on highly complex procedures where the skills of two surgeons are necessary. This can limit access to high quality care or result in providers performing services that cannot be reimbursed.

Currently HCPF only allows co-surgery reimbursement for CPT codes which CMS has assigned a co-surgery indicator of '2'. We are proposing to expand the list of surgeries for which the Department allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes approximately 2500 additional codes. This will align HCPF more closely with Medicare's co-surgery policy and create clarity for providers.

MRRAC Recommendation

- The MRRAC did not receive data on Co-Surgery, therefore did not make a recommendation.

HCPF Recommendation

- HCPF recommends to expand the list of surgeries for which HCPF allows co-surgery reimbursement to include all CPT codes which CMS has assigned a co-surgery indicator of '1', which includes 2,469 codes.
- The anticipated fiscal impact of the co-surgery recommendation is about \$1,759,670 total funds, \$514,915 General Fund.

Policy Justifications

HCPF reviewed its co-surgery policy in response to provider feedback regarding reimbursement for certain procedures when performed as co-surgeries. Providers expressed concern that the limited scope of co-surgery reimbursement does not allow the flexibility for two surgeons to collaborate on highly complex procedures where the skills of two surgeons are necessary. This can limit access to high quality care or result in providers performing services that cannot be reimbursed.

Currently HCPF only allows co-surgery reimbursement for CPT codes which CMS has assigned a co-surgery indicator of '2'. By expanding the list to include all CPT codes which CMS has assigned a co-surgery indicator of '1', this will align HCPF more closely with Medicare's co-surgery policy and create clarity for providers.



Appendices

Appendix A - Cycle 1 Year 1 Methodologies and Data

Provides explanations of methodologies and data used in this report.

Appendix B1 - Base Data Summary

Provides more detailed rate comparison benchmark summaries and results that were introduced and discussed in the narrative.

Appendix B2 - Rate Ratios

- B2(a) - Anesthesia
- B2(b) - Ambulatory Surgical Centers (ASC)
- B2(c) - FFS Behavioral Health Services
- B2(d) - Maternity
- B2(e) - Abortion
- B2(f) - Pediatric Behavioral Therapy
- B2(g) - Dental
- B2(h) - Surgery

Appendix C - Fiscal Impact

The method to calculate a fiscal impact number for a service grouping has two steps. First, within the same service grouping, subtract the repriced Colorado Medicaid expenditure amount of each impacted procedure code from the adjusted expenditure amount which is based on the targeted ratio of the benchmark recommended by MPRRAC or the department. Second, sum up the total fiscal impact amount for the whole service grouping.

Appendix D - Stakeholder Feedback

Contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings

Appendix E - Glossary and County Reference Map

Provides explanations for common terms used throughout the 2023 Medicaid Provider Rate Review Analysis Report, as well as a reference map of counties in Colorado by classification.