



COLORADO
Department of Health Care
Policy & Financing

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

November 1, 2018

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

Dear Representative Hamner:

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

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

The Department's report contains recommendations for: evaluation & management and primary care, radiology, physical and occupational therapy, maternity, physician services and surgeries, and dental services under review in year three of the rate review process.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'K Bimestefer'.

Kim Bimestefer
Executive Director

KB/KS

Enclosure(s): 2018 Medicaid Provider Rate Review Recommendation Report



Cc: Senator Kent Lambert, Vice-Chair, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF





COLORADO
Department of Health Care
Policy & Financing

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

November 1, 2018

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

Dear Mr. Pace:

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

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

The Department's report contains recommendations for: evaluation & management and primary care, radiology, physical and occupational therapy, maternity, physician services and surgeries, and dental under review in year two of the rate review process.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'K Bimestefer'.

Kim Bimestefer
Executive Director

KB/KS

Enclosure(s): 2018 Medicaid Provider Rate Review Recommendation Report



Cc: Rebecca Craig, Vice-Chair, Medicaid Provider Rate Review Advisory Committee
Lisa Foster, Medicaid Provider Rate Review Advisory Committee
Chris Hinds, Medicaid Provider Rate Review Advisory Committee
Gigi Darricades, Medicaid Provider Rate Review Advisory Committee
Rob DeHerrera, Medicaid Provider Rate Review Advisory Committee
Tim Dienst, Medicaid Provider Rate Review Advisory Committee
Jennifer Dunn, Medicaid Provider Rate Review Advisory Committee
Sue Flynn, Medicaid Provider Rate Review Advisory Committee
David Lamb, Medicaid Provider Rate Review Advisory Committee
Dixie Melton, Medicaid Provider Rate Review Advisory Committee
Dr. Carol Morrow, Medicaid Provider Rate Review Advisory Committee
Gretchen McGinnis, Medicaid Provider Rate Review Advisory Committee
Dr. Jeff Perkins, Medicaid Provider Rate Review Advisory Committee
Tom Rose, Medicaid Provider Rate Review Advisory Committee
Arnold Salazar, Medicaid Provider Rate Review Advisory Committee
Tia Saucedo, Medicaid Provider Rate Review Advisory Committee
Arthur Schut, Medicaid Provider Rate Review Advisory Committee
David Smart, Medicaid Provider Rate Review Advisory Committee
Barbara Wilkins-Crowder, Medicaid Provider Rate Review Advisory Committee
Dr. Murray Willis, Medicaid Provider Rate Review Advisory Committee
Jody Wright, Medicaid Provider Rate Review Advisory Committee
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF



2018 Medicaid Provider Rate Review Recommendation Report

November 1, 2018

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



COLORADO

Department of Health Care
Policy & Financing

I. Executive Summary

This report contains the work of the Colorado Department of Health Care Policy & Financing (the Department) to review rates paid to providers under the Colorado Medical Assistance Act and contains the Department's findings and recommendations for six broad categories of service: evaluation & management and primary care, radiology, physical and occupational therapy, maternity, physician services and surgeries, and dental. The rate review process was informed by rate benchmark comparisons, access analyses, stakeholder feedback, and the Medicaid Provider Rate Review Advisory Committee (MPRRAC) feedback and recommendations. Medicare rates were used as the rate benchmark comparison for four of the six broad categories of service. Service rates paid by comparable Medicaid states were used as the benchmark comparison for maternity and dental services.¹

Evaluation & Management and Primary Care

The Department found payment rates for evaluation & management and primary care services were 85.09% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 17.64% and 313.03% of the benchmark.

The Department recommends:

1. A budget-neutral rebalancing of certain individual evaluation & management and primary care rates with payments below 80% and above 100% of the benchmark.

Radiology

The Department found payment rates for radiology services were 81.86% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 8.76% and 397.12% of the benchmark.

The Department recommends:

2. A budget-neutral rebalancing of certain individual radiology rates with payments below 80% and above 100% of the benchmark.

Physical and Occupational Therapy

The Department found payment rates for physical and occupational therapy services were 82.58% of the benchmark. Rate benchmark comparisons varied widely; payments varied between 23.09% and 389.13% of the benchmark.

The Department recommends:

3. A budget-neutral rebalancing of certain individual physical and occupational therapy rates with payments below 80% and above 100% of the benchmark.

¹ For more information regarding benchmarks, including benchmark descriptions and methodologies, see the [2018 Medicaid Provider Rate Review Analysis Report](#) (pp.4).



Maternity

Access analyses in certain areas of the state were initially inconclusive, however, further analysis suggests access is sufficient. The Department found payment rates for maternity services were 69.49% of the benchmark.

The Department recommends:

4. An increase to maternity service rates, not to exceed 80% of the benchmark.

Physician Services and Surgeries

The Department found Medicare and most other state Medicaid agencies pay providers differently depending on the place of service; Colorado Medicaid does not. Access analyses in certain areas of the state were inconclusive. The Department found payment rates for physician services and surgeries were 66.96% and 68.11% of the benchmark, respectively. Rate benchmark comparisons varied widely. For example, physician service payments varied between 3.05% and 458.44% of the benchmark.

The Department recommends:

5. A payment methodology for physician services and surgeries that differentiates rates based on place of service.
6. For the regions where the Department's access analysis was inconclusive, the Department will continue access analysis and utilization monitoring.
7. A budget-neutral rebalancing of certain individual physician service and surgery rates with payments below 80% and above 100% of the benchmark.

Dental

The Department found payment rates for dental services ranged from 98.07% to 153.45% of the benchmarks.

The Department recommends:

8. An increase to certain preventive dental service rates.

II. Introduction

Background

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

- assess and, if needed, revise a five-year schedule of rates under review;²

² The Department received approval from the Joint Budget Committee to exclude certain rates from the rate review process. Rates were generally excluded when: rates are based on costs; there is an established process

- conduct analyses of service, utilization, access, quality, and rate comparisons to an appropriate benchmark for services under review and present the findings in a report published the first of every May;
- develop strategies for responding to the analysis results; and
- provide recommendations on all rates reviewed and present in a report published the first of every November.

In accordance with the statute, the Department also established the MPRRAC, which assists the Department in the review of provider rate reimbursements.

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

Category of Service	Sub-Category of Service
Evaluation & management and primary care	<ul style="list-style-type: none"> • Evaluation & management services (procedure codes 99201-99499) • Vaccines and immunizations (procedure codes 90281-90749, S0195) • Family planning services (procedure codes billed with the family planning modifier; see the Family Planning Services Rate Schedule for a list of applicable procedure codes) • Alternative Payment Methodology (APM) codes³
Radiology	<ul style="list-style-type: none"> • Radiology services (procedure codes 70010-79999, S8032, and G0297)
Physical and occupational therapy	<ul style="list-style-type: none"> • Physical and occupational therapy services (procedure codes 97001-97799)
Maternity	<ul style="list-style-type: none"> • Maternity services (procedure codes 59000-59899 and H1005)
Physician services ⁴	<ul style="list-style-type: none"> • Allergy services (procedure codes 95004-95199) • Neurology services (procedure codes 95812-96020) • Infusion and similar products (procedure codes 96372-96571) • Sleep studies (procedure codes 95782-95811) • Miscellaneous services (procedure codes 97802-99199 and 95250-95251) • Skin procedures (procedure codes 96900-96999) • Genetic counseling (procedure codes 96040 and S0265)
Surgeries ⁵	<ul style="list-style-type: none"> • Genital system surgeries (procedure codes 54000-58999) • Nervous system surgeries (procedure codes 61000-64999) • Urinary system surgeries (procedure codes 50010-53899) • Endocrine system surgeries (procedure codes 60000-60699)
Dental	<ul style="list-style-type: none"> • Dental services (procedure codes D0120-D9996)

delineated in statute or regulation for rate updates; rates are a part of a managed care plan; or payments are unrelated to a specific service rate. For more information see the [Medicaid Provider Rate Review Schedule](#).

³ For more information, see the Department’s [Primary Care Payment Reform website](#).

⁴ Remaining physician services were examined in year two of the rate review process. For more information, see the [2017 Medicaid Provider Rate Review Analysis Report](#) (pp.15-58) and the [2017 Medicaid Provider Rate Review Recommendation Report](#) (pp.5-7).

⁵ Remaining surgeries were examined in year two of the rate review process. For more information, see the [2017 Medicaid Provider Rate Review Analysis Report](#) (pp.58-101) and the [2017 Medicaid Provider Rate Review Recommendation Report](#) (pp.5-8).



Table 1 - Services under review in year three of the rate review process.

On May 1, 2018, the Department published the [2018 Medicaid Provider Rate Review Analysis Report](#).

This document serves as the second report in the annual rate review process. It briefly summarizes what was learned through the rate review process, the Department's recommendations for services reviewed in year three, and considerations taken in developing recommendations. The Department's recommendations were informed by the 2018 Analysis Report and MPRRAC and stakeholder feedback, and were developed after working with the Office of State Planning and Budgeting to determine priorities and achievable goals within the statewide budget. This report is intended to be used by the Joint Budget Committee for consideration in formulating the budget for the State Department.

MPRRAC Guiding Principles

Committee members and the Department share the goal of using the rate review process to critically analyze rates, client access, provider retention, and develop appropriate recommendations. During year one of the rate review process, the MPRRAC identified a series of overarching guiding principles to guide their evaluation of Department-presented information and their development of recommendations. Those guiding principles were used again during year three:

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

The MPRRAC also made two over-arching recommendations this year that apply to all the committee's recommendations for services under review in year three:

- The optimal goal for service payments is parity with Medicare or other appropriate benchmarks based on the services being provided; however, the following recommendations recognize that goal may not be achievable in the short term.
- Any changes in payment rates should take into account policy-specific rates carve-outs for codes that are paid at higher than benchmark rates.

Format of Report

This report is separated into six sections: evaluation & management and primary care, radiology, physical and occupational therapy, maternity, physician services and surgeries, and dental services. Each section contains:

- Summary of Findings - a summary of the Department's findings through the rate review process, which includes rate comparison and access analyses.
- Department Recommendations

- **Considerations** – a summary of the Department's considerations, which includes information and data that informed the development of the Department's recommendations. The Department notes where it aligns with MPRRAC recommendations and offers explanations where it does not.⁶

III. Year Three Recommendations

Evaluation & Management and Primary Care

Summary of Findings

The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for evaluation & management and primary care services were 85.09% of the benchmark. The results also revealed that rate benchmark comparisons varied widely by individual service. For example, while one service payment was 17.64% of the benchmark, another service payment was 313.03% of the benchmark.⁷ Analyses suggest that evaluation & management and primary care payments were sufficient to allow for client access and provider retention.⁸

Department Recommendations

1. The Department will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

This recommendation aligns with the Governor's November 1, 2018 executive budget request R-13, "Provider Rate Adjustments".

Considerations

This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services, bringing greater alignment to evaluation & management and primary care services without compromising access. It is informed by findings of the [2018 Medicaid Provider Rate Review Analysis Report](#) and Department subject matter expert research.

After evaluating individual services with payments below 80% and above 100% of the benchmark, the Department may make budget-neutral rebalancing adjustments, within the Department's existing

⁶ For the full list of MPRRAC recommendations, see Appendix A - MPRRAC Recommendations.

⁷ Information regarding variations in rate benchmark comparisons is contained in the [2018 Medicaid Provider Rate Review Analysis Report](#); visual representations of variations in rate benchmark comparisons are contained in [Appendix F](#) of the report.

⁸ A comprehensive access and quality review of all primary care services is scheduled for submission to the Centers for Medicare & Medicaid Services in October of 2019 as part of the Colorado Access Monitoring Review Plan. As part of this report, the Department plans to continue access analysis and utilization monitoring for evaluation & management and primary care services. For example, as indicated in the [2018 Medicaid Provider Rate Review Analysis Report](#) (pp. 11-12), the Department plans to review regional data from the 2017 Colorado Health Access Survey, and the Colorado Health Institute's Access to Care Indices, including the forthcoming Medicaid Access to Care Index, to understand: the client experience; regional variation in potential access pathways to care, and realized access; and how those results may vary based on insurance type.



authority. The Department can also make this list of services available for consideration, should additional funds be needed to increase those rates below 80% of the benchmark.

Regarding evaluation & management and primary care services, the MPRRAC recommended:

The Department should conduct a budget-neutral rebalancing of rates below 85% and above 100% of the benchmark.

Committee members stated in 2017, and reiterated this year, that such recommendations to rebalance, in a budget-neutral manner, rates that are a certain percentage below and above the benchmark may not, initially, impact client access. They noted, however, that such recommendations are intended to bring logic to rates.⁹ Committee members also stated that because the committee recommends the optimal goal for service payments be parity with Medicare or other appropriate benchmarks, and because overall payments for evaluation & management and primary care services were at 85.09% of the benchmark, the Department should look to rebalance rates below 85% (rather than 80%, as recommended elsewhere) of the benchmark.

The Department agrees that the deviation from the benchmark, and the methodology used to set said rates, should be reasonably consistent across services. For consistency across similar recommendations for other service groupings, the Department recommends a budget-neutral rebalancing of certain individual evaluation & management and primary care rates with payments below 80% (rather than 85%) and above 100% of the benchmark. The Department does not recommend rebalancing all rates below 80% and above 100% of the benchmark because additional analysis would be needed to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that may affect client access and provider retention; and, as noted in the MPRRAC's general recommendation for year three services above, the Department may choose to incentivize the provision of certain services based on policy-specific considerations.

For example, the Department notes that this service grouping includes Alternative Payment Methodology (APM) codes.¹⁰ As part of the Department's efforts to shift providers from volume to value, the Department, along with stakeholders, created the APM to make differential fee-for-service payments based on provider's performance. This payment model aims to give providers greater flexibility in care provided, reward performance, and maintain transparency and accountability in payments made.

Radiology

Summary of Findings

The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for radiology services were 81.86% of the benchmark. The results also revealed that rate

⁹ Committee members also posited that logical reimbursement may indirectly allow for providers to accept more Medicaid clients and that such a move would reduce perverse incentives for medical providers to provide certain services over others (see [July 21, 2017 MPRRAC Meeting Minutes](#)).

¹⁰ The Affordable Care Act provided federal funding, known as the 1202 bump, for a temporary increase in primary care rates beginning in 2013. When federal funding expired on December 31, 2014, the Colorado General Assembly chose to continue the 1202 bump with State General Fund dollars. The APM is a transformation of the 1202 bump.

benchmark comparisons varied widely by individual service. For example, while one service payment was 8.76% of the benchmark, another service payment was 397.12% of the benchmark. Analyses suggest that radiology service payments were sufficient to allow for client access and provider retention.

Department Recommendations

2. The Department will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

This recommendation aligns with the Governor's November 1, 2018 executive budget request R-13, "Provider Rate Adjustments".

Considerations

This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services, bringing greater alignment to radiology services without compromising access. It is informed by findings of the [2018 Medicaid Provider Rate Review Analysis Report](#) and Department subject matter expert research.

After evaluating individual services with payments below 80% and above 100% of the benchmark, the Department may make budget-neutral rebalancing adjustments, within the Department's existing authority. The Department can also make this list of services available for consideration, should additional funds be needed to increase those rates below 80% of the benchmark.

Regarding radiology services, the MPRRAC recommended:

The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

The Department agrees that the deviation from the benchmark, and the methodology used to set said rates, should be reasonably consistent across services. The Department does not recommend rebalancing all rates below 80% and above 100% of the benchmark for the same reasons articulated within the evaluation & management and primary care services section above.

Physical and Occupational Therapy

Summary of Findings

The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for physical and occupational therapy services were 82.58% of the benchmark. The results also revealed that rate benchmark comparisons varied widely by individual service. For example, while one service payment was 23.09% of the benchmark, another service payment was 389.13% of the benchmark. Analyses suggest that physical and occupational therapy service payments were sufficient to allow for client access and provider retention.

The Department received written and verbal stakeholder comment regarding potential barriers to accessing certain services, which were incorporated into the [2018 Medicaid Provider Rate Review Analysis](#)

[Report](#).¹¹ Most commonly, stakeholders expressed concern regarding evaluation service code 97001, which was recently deconsolidated by the Centers for Medicare & Medicaid Service (CMS) and the American Medical Association (AMA) into three codes, based on the complexity of the service.¹² Stakeholder concerns included: that providers were not given notice of the rate change prior to implementation; that the Department should have waited to observe utilization of the three new codes before adjusting rates (as Medicare has done); that guidance on when to bill each of the three new codes is unclear; and, as a result, that the rates the Department recently set for the three new codes were not appropriate. Similarly, stakeholders expressed concern with the rate the Department set for re-evaluation service code 97164, which replaced service code 97002, and further defines the complexity of the service.¹³

Department Recommendations

3. The Department will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

This recommendation aligns with the Governor’s November 1, 2018 executive budget request R-13, “Provider Rate Adjustments”.

Considerations

This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services, bringing greater alignment to physical and occupational therapy services without compromising access. It is informed by findings of the [2018 Medicaid Provider Rate Review Analysis Report](#) and Department subject matter expert research.

After completing examinations of individual services with payments below 80% and above 100% of the benchmark, the Department may make budget-neutral rebalancing adjustments, within the Department’s existing authority. The Department can also make this list of services available for consideration, should additional funds be needed to increase those rates below 80% of the benchmark.

Regarding physical and occupational therapy services, the MPRRAC recommended:

¹¹ During the [May 18](#), [July 20](#), and [September 21](#), 2018 MPRRAC meetings, the Department received additional feedback from the same stakeholders regarding reimbursement for codes 97161, 97162, 97163 and 97164. Stakeholder feedback and committee member discussion is captured within the meeting minutes located on the [Medicaid Provider Rate Review Advisory Committee website](#).

¹² The Department’s description of the three new codes within Table 8 on p.17 of the [2018 Medicaid Provider Rate Review Analysis Report](#) is misleading; the table includes the typical length of time of the associated evaluation. The Current Procedural Terminology (CPT) coding definitions talk about both complexity and time; time is included as a secondary factor. If the two don’t align, it is up to the provider to select the appropriate code and to include sufficient information in the medical record to support billing.

¹³ At the request of the MPRRAC, the Department created a [Physical Therapy Evaluation Code Deconsolidation handout](#) for the July 20, 2018 MPRRAC meeting, which included further utilization information for the three codes in question.



1. The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.
2. For the deconsolidated physical therapy evaluation code (formerly 97001, currently 97161, 97162, and 97163), the Department should adjust the rates for each, such that the aggregate of the three new codes is reimbursed similarly to code 97001 in FY 2016-17.

For example, consider reimbursing 97161 at the current rate, increasing 97162 reimbursement to the 97001 rate in FY 2016-17, and increasing the reimbursement for 97163 proportionately.

3. Until clearer national coding guidelines are developed, Colorado Medicaid should adopt clear, time-based definitions for the deconsolidated physical therapy codes.

With respect to the committee's first recommendation above, the Department agrees that the deviation from the benchmark, and the methodology used to set said rates, should be reasonably consistent across services. The Department does not recommend rebalancing all rates below 80% and above 100% of the benchmark for the same reasons articulated within the evaluation & management and primary care services section above.

With respect to the committee's second recommendation above, the Department believes the rate setting process for the deconsolidated code 97001 was robust and produced rates that adequately compensate providers for services rendered after accounting for input factors, including but not limited to: indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations. To the extent that there is confusion within the provider community about when to bill the new codes 97161, 97162, and 97163, and to the extent that such confusion may have led certain providers in 2018 to, for example, bill a high complexity evaluation using a low complexity code, the Department believes the solution is one of education. The Department does not recommend increasing the rates for codes 97162 and 97163, which were set through the above rate setting process.

With respect to the committee's second and third recommendations above, it is not the Department's role to educate providers on correct coding. To the extent that providers are unclear about appropriate coding practices they should consult a billing specialist or their professional association.¹⁴ The Department is prohibited from creating definitions for Current Procedural Terminology (CPT) codes, which are developed, maintained, and copyrighted by the AMA.

¹⁴ The American Physical Therapy Association, for example, which worked with the AMA to develop the three new codes, and which describes these codes as "low-complexity, medium-complexity, and high-complexity", provides several tools and further guidance regarding appropriate billing of these codes on their [website](#).



Maternity

Summary of Findings

The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for maternity services were 69.49% of the benchmark.¹⁵ Individual maternity service rate ratios ranged from 29.73% to 95.68%. Analyses suggest that maternity service payments were sufficient to allow for client access and provider retention.

Department Recommendations

4. The Department recommends an increase to maternity service rates, not to exceed 80% of the benchmark.

This recommendation aligns with the Governor's November 1, 2018 executive budget request R-13, "Provider Rate Adjustments"

Considerations

In 2016, approximately 45% of babies in Colorado were born to mothers enrolled in Colorado Medicaid (including the Child Health Plan Plus program). While initial access analyses in the [2018 Medicaid Provider Rate Review Analysis Report](#) were inconclusive for Health Statistics Regions (HSRs) 6 and 9, subsequent analysis indicates Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) provide maternity services within these regions at a higher rate than in most other regions; FQHCs and RHCs in HSR 6 provide maternity services at a higher rate than in any other region of the state.^{16,17} While analyses suggest that payments were sufficient to allow for client access and provider retention, the Department notes that payments for maternity services are below 80-100% of other comparator state Medicaid rates.

The Department recognizes the importance of quality maternity care and supports efforts to reduce the payment gap between current Colorado Medicaid rates and those of other Medicaid states. However, the Department does not propose an increase in excess of 80% of the benchmark. As the largest insurer of pregnant women in the state, the Department believes that the best long-term approach to increasing reimbursement for maternity services is through a quality incentive and value-based payment lens. For

¹⁵ Medicare covers certain maternity services for individuals under 65 years old who qualify for Medicare due to disability; however, because the population eligible for Medicare maternity services is considerably different from the population eligible for Colorado Medicaid's maternity services, the Department compared exclusively to other states' Medicaid rates. Those states were: Arizona, Nebraska, Oklahoma, Oregon, and Wyoming.

¹⁶ Analysis of FQHC and RHC utilization and rates is excluded from the rate review process, therefore, this trend was not captured in the initial access analysis.

¹⁷ A comprehensive access and quality review of all maternity related services is scheduled for submission to the Centers for Medicare & Medicaid Services in October of 2019 as part of the Colorado Access Monitoring Review Plan. As part of this report, the Department plans to continue access analysis and utilization monitoring for maternity services generally and to take specific action to further analyze trends in HSR 9. For example, as indicated in the [2018 Medicaid Provider Rate Review Analysis Report](#) (pp. 20), the Department plans to examine Colorado Department of Public Health and Environment provider directory data to understand if the number of providers in HSR 9 varies based on insurance type, and to conduct county-specific investigations that may indicate if trends in one county are driving results for the entire region.



example, the Department currently plans to include maternal safety measures within the Hospital Quality Incentive Program. As we move forward in our pursuit to improve service quality through the development of quality incentive and value-based payment programs, the Department commits to further thinking through how best to incorporate maternity services.

Regarding maternity services, the MPRRAC recommended:

The Department should seek funding from the legislature to bring maternity service rates to 90% of the benchmark.

Committee members stated that, while access may appear sufficient, perhaps because Medicaid is the largest payer in the state, rates appear uniformly low when compared to the benchmark and should be increased. They further posited that, because the benchmark in this case is not Medicare but, rather, other Medicaid states' rates, which are often lower than the rates paid by Medicare, rates should be increased to 90% (rather than 80%) of the benchmark.

The Department notes that current Medicare reimbursement rates do not significantly differ from the rates paid by the Medicaid comparator states used to establish the benchmark. Therefore, in addition to the reasoning above, the Department does not recommend increasing rates to 90% of the benchmark.

Physician Services and Surgeries

Summary of Findings

The Department reviewed eight sub-categories of physician services and six sub-categories of surgery in year two of the Rate Review process and reviewed the remaining categories of service this year.¹⁸ The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for physician services and surgeries under review this year were 66.96% and 68.11% of the benchmark, respectively.¹⁹ The results also revealed that rate benchmark comparisons varied widely by individual service. For example, while one physician service payment was 3.05% of the benchmark, another was 458.44% of the benchmark. Like last year, while initial access analyses in the [2018 Medicaid Provider Rate Review Analysis Report](#) were inconclusive for a few services in a few Health Statistics Regions and further analysis is ongoing, analyses suggest that physician services and surgery payments were sufficient to allow for client access and provider retention.

Research in year two revealed that Medicare, many other state Medicaid agencies, and the Department-administered Child Health Plan Plus program, pay providers differently depending on the place of service. For example, Medicare often pays providers one rate for a service delivered in a non-facility setting, and

¹⁸ In year two of the Rate Review process, the Department reviewed the following physician services: ophthalmology, speech therapy, cardiology, cognitive capabilities assessment, vascular, respiratory, ear, nose and throat, and gastroenterology. The Department also reviewed the following surgery services: digestive systems, musculoskeletal systems, cardiovascular systems, integumentary systems, eye and auditory systems, and respiratory systems. See the [2017 Medicaid Provider Rate Review Analysis Report](#) (pp.15-101) and the [2017 Medicaid Provider Rate Review Recommendation Report](#) (pp.5-8) for more information. Refer to Table 1 on page 3 of this report for a list of physician services and surgeries reviewed this year.

¹⁹ Note: For the eight physician services under review in year two, payments ranged from 61.61% to 116.83% of the benchmarks, and payments were 71.70% of the benchmark for the six surgeries under review.

another rate for the same service delivered in a facility setting. This is different than Colorado Medicaid's payment methodology, which utilizes a single fee schedule, regardless of place of service. In 2017, committee members shared that differential payment by place of service is customary practice for private payers. The Department subsequently committed to pursuing a payment methodology for physician services and surgeries that differentiates rates based on place of service and is in the process of developing two fee schedules.

Department Recommendations

As the Department recommended last year regarding physician services and surgeries,

5. The Department recommends and will pursue a payment methodology for physician services and surgeries that differentiates rates based on place of service.
6. For regions where the Department's access analysis was inconclusive, the Department will continue access analysis and utilization monitoring, which will be reported in the Department's Access Monitoring Review Plan, which will be published in October 2019.^{20,21} The Department will also communicate results from continued analysis and monitoring to Regional Accountable Entities and the Department's Provider Relations Unit to inform other efforts impacting access.
7. The Department will evaluate individual services that were identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.

Recommendations 5 and 7 align with the Governor's November 1, 2017 executive budget request R-9, "Provider Rate Adjustments".

Considerations

Recommendation 5 will allow the Department to account for differences in service provision in non-facility and facility settings.²² It is informed by findings of the [2017 Medicaid Provider Rate Review Analysis Report](#), [2018 Medicaid Provider Rate Review Analysis Report](#), and Department subject matter expert research. It also supports the MPRRAC's guiding principle to utilize an existing rate setting methodology where

²⁰ 42 CFR 447.203, Methods for Assuring Access to Covered Medicaid Services, requires states include within an Access Monitoring Review Plan (AMRP) submitted to the Centers for Medicare & Medicaid Services every three years, an analysis of access to five broad categories of service, and to any services for which the state Medicaid agency has identified possible access issues. Three full time equivalent Department positions were created to undertake this work and will conduct ongoing analysis of access to these services in these regions.

²¹ For example, as indicated in the [2018 Medicaid Provider Rate Review Analysis Report](#) (pp. 23-24 and 26), the Department plans to examine Colorado Department of Public Health and Environment provider directory data to understand if the number of providers in HSRs 9, 10 and 14 varies based on insurance type, and to conduct county-specific investigations that may indicate if trends in one county are driving results within each region.

²² Non-facility rates for physician services and surgeries tend to be higher than facility rates. This is because payments to non-facility locations, such as clinics and offices, account for the overhead costs associated with providing those services. Conversely, payments to facility locations, such as hospitals, are lower because facility locations already receive payments for overhead expenses, in the form of APR-DRG and EAPG payments. More information regarding Medicare's two fee schedules is outlined in the [2017 Medicaid Provider Rate Review Analysis Report](#) (pp.11-13).



appropriate; in this case a methodology used by Medicare and other state Medicaid agencies. This recommendation also aligns with the MPRRAC's 2017 recommendation:

The Department should begin paying for physician services and surgery based on place of service, using Medicare as a model.

Recommendation 6 will ensure continued evaluation of access sufficiency for the services under review, including in those regions where initial analysis was inconclusive. As part of this analysis, the Department will seek to determine whether any identified issues are unique to Medicaid.

Recommendation 7 will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services, bringing greater alignment to surgeries without compromising access. It is informed by findings of the [2017 Medicaid Provider Rate Review Analysis Report](#), [2018 Medicaid Provider Rate Review Analysis Report](#), and Department subject matter expert research.

After completing analysis to account for differences in service provision in non-facility and facility settings, and examinations of individual services with payments below 80% and above 100% of the benchmark, the Department may make budget-neutral rebalancing adjustments, within the Department's existing authority. Should the Department determine that additional funds are needed to increase those rates below 80% of the benchmark, the Department would need to request those funds through the regular budget process.

Regarding physician services and surgeries, this year the MPRRAC recommended:

1. The aggregate expenditures for these services is significantly below the 80% benchmark goal, thus the committee recommends that the Department should seek additional funding to increase overall spending in this area.
2. Furthermore, the Department should perform a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

With respect to the committee's first recommendation above, the Department notes that payments for physician services and surgeries are below the threshold identified in the Payment Philosophy section of the [2018 Medicaid Provider Rate Review Analysis Report](#), pp.2-3). The Department does not recommend additional funding for these services at this time. The Department seeks to avoid resetting all physician services and surgery rates twice, given the commitment to pursuing establishing differential rates based on place of service. The Department may offer additional recommendations next year, once work to develop two fee schedules based on place of service has advanced.

With respect to the committee's second recommendation above, the Department agrees that the deviation from the benchmark, and the methodology used to set said rates, should be reasonably consistent across services. The Department does not recommend rebalancing all rates below 80% and above 100% of the benchmark for the same reasons articulated within the evaluation & management and primary care services section above.



Dental

Summary of Findings

The results of the [2018 Medicaid Provider Rate Review Analysis Report](#) revealed that the Department's payments for dental services ranged from 98.07% to 153.45% of the benchmarks.²³ Analyses suggest that dental service payments were sufficient to allow for client access and provider retention.²⁴

The Department received verbal stakeholder comment from the Colorado Dental Association in the September MPRRAC meeting regarding unique considerations when evaluating dental service rates.²⁵ Feedback included:

- The adult dental benefit is new to Colorado Medicaid, rates for these services were recently and thoughtfully set by the Department, the program is working well, and more time should likely pass to collect better trend data before considering rate reductions;
- While rates appear high compared to the benchmarks, the benchmark comparators are other Medicaid states (not Medicare), that many Medicaid states do not provide adult dental service coverage, and that those that do often do not reimburse adequately;
- The legislature through its appropriations process has chosen to incentivize certain services, such as prevention, basic fillings, and extractions, and that these decisions have helped increase access to dental services across the state; and
- While client utilization may appear low, low utilization of dental services is a national trend across all payers and Colorado Medicaid client and provider participation rates are among the highest in the nation.

Department Recommendations

8. The Department recommends an increase to certain preventive dental service rates.

This recommendation aligns with the Governor's November 1, 2018 executive budget request R-13, "Provider Rate Adjustments".

Considerations

The Department notes that payments for dental services exceed those of most other comparator state Medicaid rates; however, the Department believes rates overall are appropriately set and should not be

²³ Medicare coverage typically does not include routine dental coverage, such as dental exams, cleanings, fillings, crowns, and bridges. Therefore, the Department compared exclusively to other states' Medicaid rates. Those states were: Montana, Nebraska, New Mexico, Oklahoma, Oregon, Tennessee, and Wyoming.

²⁴ Colorado Medicaid partners with DentaQuest, which operates as an Administrative Services Only organization (ASO), to help clients find a dentist and manage dental benefits. DentaQuest issued a [Health First Colorado Dental Program State Fiscal Year 2017 Annual Report](#) in September 2018. Also in September, the Department provided the MPRRAC with a [Dental Services Scatterplot](#) similar to those found in [Appendix F](#) of the May analysis report. These materials, in addition to the [2018 Medicaid Provider Rate Review Analysis Report](#), informed Department and committee member discussion ahead of final recommendations.

²⁵ Stakeholder feedback and committee discussion can be found in the [September 21, 2018 MPRRAC Meeting Minutes](#).



adjusted at this time. The Department agrees with the Colorado Dental Association comments above and believes dental care to be a high value service.

In 2013, [SB 13-242](#) authorized Colorado Medicaid to begin providing dental services to adults and imposed an individual member annual cap of \$1,000 on services received.²⁶ As noted in the bill, regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care. To this end, and in consultation with the Department's dental contractor, DentaQuest, the Department has identified a handful of preventive dental services for both children and adults that would benefit from a rate increase.²⁷

Regarding dental services, the MPRRAC made no recommendation. Instead they stated:

Dental service activities are going well and the committee has no recommendations for changing Dental rates.

²⁶ While unit limits exist for certain Colorado State Plan Medicaid services, adult dental services are the only State Plan Medicaid services subject to a dollar limit, which mitigates over-expenditure.

²⁷ These codes, while not all belonging to the preventive code category, are preventive in nature and include: D1110, D1120, D1206, D1208, D1351, D1352, D1353, D4346, D4910, and D0190.

Appendix A – MPRRAC Recommendations

Below are the MPRRAC's recommendations for services under review in year three of the rate review process. The discussions that precipitated these recommendations can be found in the [July 20, 2018 MPRRAC Meeting Minutes](#), and the [September 21, 2018 MPRRAC Meeting Minutes](#), found on the Department's [Medicaid Provider Rate Review Advisory Committee website](#).

General Recommendations

The optimal goal for service payments is parity with Medicare or other appropriate benchmarks based on the services being provided; however, the following recommendations recognize that goal may not be achievable in the short term.

Any changes in payment rates should take into account policy-specific rates carve-outs for codes that are paid at higher than benchmark rates.

Evaluation & Management and Primary Care Recommendation

The Department should conduct a budget-neutral rebalancing of rates below 85% and above 100% of the benchmark.

Radiology Recommendation

The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

Physical and Occupational Therapy Recommendation

Regarding physical and occupational therapy services, the MPRRAC recommended:

1. The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.
2. For the deconsolidated physical therapy evaluation code (formerly 97001, currently 97161, 97162, and 97163), the Department should adjust the rates for each, such that the aggregate of the three new codes is reimbursed similarly to code 97001 in FY16-17.

For example, consider reimbursing 97161 at the current rate, increasing 97162 reimbursement to the 97001 rate in FY16-17, and increasing the reimbursement for 97163 proportionately.

3. Until clearer national coding guidelines are developed, Colorado Medicaid should adopt clear, time-based definitions for the deconsolidated physical therapy codes.

Maternity Recommendation

The Department should seek funding from the legislature to bring maternity service rates to 90% of the benchmark.

Physician Services and Surgeries Recommendation

Regarding physician services and surgeries, the MPRRAC recommended:



1. The aggregate expenditures for these services is significantly below the 80% benchmark goal, thus the committee recommends that the Department should seek additional funding to increase overall spending in this area.
2. Furthermore, the Department should perform a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

Dental Recommendation

Dental service activities are going well and the committee has no recommendations for changing dental rates.

