



MINUTES OF THE MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE

The Colorado Department of Health Care
Policy and Financing
303 East 17th Avenue, 7th Floor Conference Room

Friday, June 17, 2016
9:00 AM – 4:00 PM

1. MPRRAC Members Present (in person or via phone)

Bruce Densley, Tim Dienst, Jennifer Dunn, Sue Flynn, Lisa Foster, Deborah Hart, David Lamb, Dixie Melton, Gretchen McGinnis, Wilson Pace, Jeff Perkins, Tom Rose, Arnold Salazar, Arthur Schut, Barbara Wilkins-Crowder, Murray Willis, Jody Wright.

2. Agenda Review

Jeff Perkins, Committee Chair, spoke about this meeting's purpose. He briefly reiterated work done to date. Committee members and stakeholders have attended and been involved in multiple Department-led presentations on year one's six services. Since the Department released the 2016 Analysis report, Jeff explained that MPRRAC members divided themselves into workgroups, by service, to review the report and create presentations that highlight data observations, suggest guiding principles, and outline workgroup's drafts of preliminary MPRRAC recommendations.

Regarding the meeting's agenda, Jeff explained services would be reviewed in five one-hour blocks. Forty minutes would be devoted to committee discussion, ten minutes for stakeholder comment, and ten minutes for committee members to vote on their recommendations. Jeff said if preliminary recommendations hadn't been finalized by the end of the meeting, the MPRRAC could discuss how to proceed. Workgroups were also asked to develop guiding principles. Jeff said there would time at the end of the meeting to discuss and agree on overall guiding principles for the MPRRAC in the development of their recommendations.

3. Laboratory Services

The laboratory services workgroup gave a presentation of data observations, impression of overall rate adequacy, potential system-wide effects of reimbursement, applicable principles, and high-level recommendations. Jeff Perkins was the presenter.

Discussion

The Committee discussed the tough timing of the OIG report results, mentioned in the 2016 Medicaid Provider Rate Review Analysis Report (Analysis Report), which were published at the same time as the Department's 2016 Recommendations Report. It was suggested that the Committee and the Department take note of this timing mismatch when developing

recommendations, specifically, that it might be problematic to finalize a recommendation in November 2016 when rates won't be known until January 2017.

Jeff Perkins, asked that, in future Analysis Reports, the Department provide more information regarding why particular states were deemed comparable or not comparable.

Gretchen Hammer, the Medicaid Director, said that the Department could also investigate laboratory rates in the All Payer Claims Database (APCD) data. Wilson Pace noted that some laboratory service providers are now providing direct to consumer services, with advertised costs, and that the Department could look into that information as well.

Gretchen Hammer and Jeremy Tipton, the Payment Reform Unit Manager, spoke about APCD data. They commented on how APCD data was used in a response to the Legislature in 2015.¹ They also commented on some of the challenges with using APCD data, namely that obtaining the data requires funds, it can only be used for the specific and narrow scope delineated ahead of time, and it must be destroyed once the analysis is complete. Jeremy outlined that the Department did not have time to re-request the data for the 2016 Analysis Report.

Jeremy also stated that the Department cannot compare to all benchmarks, all the time. Specifically, he pointed to the statute requirements that rate comparisons could be to Medicare, private payers, and/or other state Medicaid agencies. He explained that three separate rate comparisons for all rates would not be reasonable. Instead, the Department picked the best available benchmark to create a single, overall benchmark. Jeremy said that the Department can work with the Committee next year to examine potential benchmarks to determine the best comparisons.

Jeremy offered his opinion regarding the recommendations, saying that he was wary about tying our rates to other state Medicaid agencies, because our rates would then be tied to the actions of other state legislatures.

Committee members expressed concern that the timing of the new Medicare rates for laboratory services might result in recommendations that impact the budget and utilization in unforeseen ways. Gretchen Hammer reminded everyone that the Department continues to do its rate setting work, and won't stop this work, including monitoring and adapting to changes as appropriate.

The Department also committed to faithfully representing the Committee's recommendations in the Department-authored 2016 Medicaid Provider Rate Review Recommendation Report (Recommendation Report), even if the Department, through its internal analysis, doesn't share that recommendation.

Stakeholder Comment

There was no stakeholder comment.

¹ FY 2014-15 Request for Information #1 can be found via:
<https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202014-15%20RFI%20%231.pdf>

Preliminary Recommendations

The MPRRAC made a preliminary recommendation that:

- the Department continue its annual rate setting process, particularly for laboratory services that are not reimbursed by Medicare; and
- for laboratory services reimbursed by Medicare, if final 2017 Medicare rates are available in time for the 2017-2018 budget cycle, and assuming that the 2017 Medicare rates are based on the OIG report, the Department set rates at 95% of the 2017 Medicare rates.

4. Home Health Services

The home health services workgroup gave a presentation of data observations, impression of overall rate adequacy, potential system-wide effects of reimbursement, applicable principles, and high-level recommendations. Sue Flynn presented.

Discussion

Committee members discussed the comparison states used in the Analysis Report and again emphasized that they would like more information to understand how and why comparator states were chosen.

The home health workgroup suggested using quality of care metrics in rate setting, then and discussed with the rest of the Committee and concluded this would be an ideal-state, workgroup members stated they understood that gathering this information can be difficult. The Department and the Committee also noted that Medicare is looking more and more at quality metrics with regards to payments.

Gretchen Hammer noted that the Department has a variety of mechanisms currently related to payments and quality that, though more focused on the primary care setting, the Department could think through how to apply to this work, were the Committee to give that recommendation for long term care.

Wilson Pace inquired about the extra resources that the Department might need were it to pursue more complex payment methodologies. Gretchen noted that when there are confusing or complex payment methodologies and policies, more conversations and education needs to take place, but she wasn't going to make a comment on the internal resource needs for more complex payment methods at this time.

The Committee and Department had a conversation regarding the need to further research a few factors related to reimbursement rates and payment methodologies:

- lump sum reimbursement versus time increment reimbursement;
- Medicare's LUPA rate and a proposed CMS rule to alter the requirements to receive home health services for Medicare recipients;
- mileage reimbursements for home health that differ from services such as EMT (where a provider goes to multiple locations in one trip, versus EMT goes out and back); and
- how/if geographic considerations could be used in setting rates to alleviate rural access issues.

Bruce Densley noted that he did not know of any private payers that reimburse for mileage for

home health services.

Regarding geographic considerations, the Department noted that there is movement from federal partners to potentially allow for more investigation into basing reimbursement on geographic considerations. Kevin Martin, Fee for Service Rates Manager, also asked that Committee members outline their main goal in suggesting reimbursing using geographic considerations. Committee members pointed towards attempts to get services for clients in rural areas.

Gretchen Hammer highlighted that the new federal Access to Care rule asks a different question, which is: is the access to care for Medicaid clients in an area similar to the access to care for other payers in the same area. The question that the rate review process is examining involves the sufficiency of rates to allow for client access.

Jeremy Tipton asked certain Committee members for cost reports and margin information to help the Department evaluate the recommendations. Committee members supported this request, pointing out that such information will help the Committee understand things like employee retention issues.

Gretchen also commented that phasing-in recommendations might be something that the Department supports, but it might not be something that the state legislature would commit to via their process.

Stakeholder Comment

One stakeholder commented that it is difficult to recruit and retain staff with the current reimbursement rates for registered nurses (RN) because of the hourly wages. She also noted that it is hard to compete with hospital's rate of pay, benefits, and paid time off.

Eric Goff, representing All State Home Health and Agave Home Health, provided a written statement and supporting documentation, and reiterated what some committee members previously said; he didn't think the states chosen by the Department were good comparable states. He also said that the LUPA rate would be a good comparison for home health.

Preliminary Recommendations

The MPRRAC made a preliminary recommendation that:

- the Department increase rates towards 90% of LUPA over three years,
- the Department examine geographic (e.g., reimbursing differently based on locations such as rural, frontier, and urban) and transportation considerations, and
- the Department investigate, as an alternative to the current lump sum payment methodology, reimbursement methodologies that are a "base plus".

5. Private Duty Nursing Services

The private duty nursing services (PDN) workgroup gave a presentation of data observations, impression of overall rate adequacy, potential system-wide effects of reimbursement, applicable principles, and high-level recommendations. Lisa Foster presented.

Discussion

The PDN workgroup expressed interest in the number of clients that requested services and didn't

receive authorization for those services. The Committee and Department identified that multiple questions were being asked:

- what are the hours requested that aren't approved;
- how many requests exist that have no hours approved; and
- how many patients don't make a request at all.

The Department has information on the first two questions, but does not have data regarding the patients that are unable to make a request. The Department commented that it may be home health agencies and case management agencies have a better understanding of patients that are unable to request PDN services.

Jeremy Tipton commented that the Department would like to obtain this sort of information from home health agencies, as well as information regarding their patient waitlists and information about staffing shortages.

The Committee questioned if other institutions, such as hospitals, might have information about their clients that they would like to discharge and subsequently receive PDN services but that, because they cannot secure those services, do not discharge the patients. The Committee suggested that the Department reach out to Children's Hospital, St. Mary's Hospital, Rocky Mountain Hospital, and St. Joe's Hospital to survey and see if the Department can gather this information.

Gretchen Hammer commented that there is a state-wide nursing shortage, so this access issue may be broader and more complex than just Colorado Medicaid.

As the Committee discussed the PDN workgroup's recommendation to increase LPN rates, they noted that the Committee and Department might be able to use this as a testable prediction. Specifically, if LPN rate increases, the Department could examine changes in the use of LPNs versus RNs by PDN clients. Lisa Foster commented that there are services that can be done by both LPNs and RNs.

Kevin Martin asked for the information and data that was used by the workgroup members to develop the recommendation for an increased LPN rate (from \$30/hour to \$35-\$37.50/hour). Lisa Foster said that this recommendation came from the rates she has on file of comparable states (specifically Washington, Oregon, and Minnesota).

Stakeholder Comment

Eric Goff said that, in addition to examining how PDN services may be a more appropriate and less costly setting as compared to hospitals, the Department should also examine - or try to make a comparison to- long-term acute care hospitals (LTACs).

Preliminary Recommendations

The MPRRAC made a preliminary recommendation that:

- the Department gather more information about LPN reimbursement rates and/or wages from hospitals and LTACs to help investigate appropriate increases in the LPN rate for PDN services; and

- similar to Home Health, the Department, consider some mechanism to increase reimbursement in rural areas.

6. Non-Emergent and Emergency Medical Transportation

The non-emergent and emergency medical transportation (NEMT/EMT) workgroup gave a presentation of data observations, impression of overall rate adequacy, potential system-wide effects of reimbursement, applicable principles, and high-level recommendations. Tim Dienst presented.

Discussion

Tim pointed out that information on EMS trips that do not result in a patient transfer does not show up in the claims data.

In response to committee members' questions regarding whether or not other state Medicaid agencies and private payers reimburse for transportation services that do not result in a transport to a hospital, Tim said that a few other state Medicaid agencies pay for treat and release services, but it is not the norm. Tim said he is also unaware of any private payers that reimburse for treat and release in Colorado. Committee members commented that not reimbursing for treat and release might lead to patients being transported to locations associated with higher costs of care (e.g., hospitals) when that isn't necessary.

Tim also discussed that the ability to use other types of transportation (other than an ambulance) could result in lower-cost, more appropriate transports.

Tim said that EMT is experiencing similar problems to Home Health and Private Duty nursing in difficulty in recruiting and retaining staff and volunteers, specifically in rural areas.

Tim echoed the idea that EMT rates should be compared to additional states in the Analysis Report. Tim also said that with Medicaid expansion, the percent of his organization's clients that have either Medicare or Medicaid has increased.

Tim pointed out that when the workgroup was thinking about recommendations, they realized that there is essentially a pot of money and, barring an increase to that pot of money, recommending an increase in reimbursement for one service would result in a "winners and losers" situation where other services might receive less reimbursement.

Kevin Martin asked Tim and the Committee for more information on what geographic considerations would go into a payment modifier (referring to a recommendation on the workgroups' presentation), citing that the Department already reimburses based on mileage. Tim said that it is mainly mileage, but he said he would like more information regarding what are urban versus rural geographic considerations.

After presenting recommendations, Tim said that he would prioritize recommendations as they were presented (from short term to long term). Tim also said that his organization is in the process of gathering more data on surrounding state reimbursement rates.

Gretchen Hammer wanted to let the Committee know that, with regards to recommendations, it would be helpful if the Committee allowed for short-term and long-term recommendations to be

examined simultaneously. Specifically, she said that in the case of NEMT/EMT services, the Department, given the current budget environment, might have to investigate the long-term goal of increased federal matches in an attempt to meet the short-term goal of increasing transportation rates.

Gretchen and Committee members also discussed the idea that the recommendation to research and take into account geographic considerations has been present in other service recommendations. Committee members agreed that the concept of investigating reimbursement with geographical considerations might better serve as a guiding principle, rather than a repeated recommendation.

Kevin Martin, referring to the guiding principle mentioned earlier of making recommendations that result in care in the most effective, least costly environment, wanted to know if the workgroup and/or Committee had any recommendations about NEMT. Gretchen Hammer noted that internally the Department is working on NEMT improvements, but a recommendation from the Committee regarding NEMT would help the Department's work.

Stakeholder Comment

One stakeholder commented that he agrees that EMT is underpaid and supported the idea of having a goal to increase EMT reimbursement rates closer to Medicare over the next three years. He also supported the idea of investigating how to increase NEMT rates.

An NEMT stakeholder commented that providing services, especially for him in the Northeast corner of the state, is difficult. The stakeholder pointed out that for things like dialysis appointments, the lack of transportation can lead to emergency situations if patients can't get the care they need. He said he also supported increased reimbursement.

There was also a Committee discussion regarding third-party liability issues and EMT reimbursement and Gretchen Hammer committed to raise this issue with the new Legal Director, Paul Ritzmah.

Preliminary Recommendations

The MPRRAC made a preliminary recommendation that:

- The Department increase rates for EMT/NEMT towards a goal of parity to Medicare and/or surrounding states over three years, including investigating the use of supplemental sources (e.g., enhanced federal match);
- The Department look at initiating reimbursement for treat and release and supplies used codes; and
- The Department investigate reimbursing for alternative transportation vehicles (i.e. vehicles other than ambulances).

7. Physician-Administered Drugs

The physician-administered drugs workgroup gave a presentation of data observations, impression of overall rate adequacy, potential system-wide effects of reimbursement, applicable principles, and high-level recommendations. This presentation also included information from the workgroup regarding data and analysis deficiencies and was presented by Jeff Perkins.

Discussion

Jeremy Tipton drew attention to the fact that the statute does not require a comparison of services between sites and that analysis was done for broad services, not individual codes.

Within the data deficiency charts presented, Jeff said that the drugs with no comparison to Medicare rates are mostly contraceptives. Numbers in green indicate Medicaid reimbursement is more than Medicare, numbers in red indicate Medicaid reimbursements less than Medicare, and orange numbers indicate reimbursement is more or less the same.

Jeff answered a clarifying question and stated that rates are only for the cost of the drug; there are separate drug administration codes and rates that are not being examined this year.

Regarding the paragraph in the Analysis Report on CMS's proposed rule change, Gretchen Hammer clarified that the intent of the paragraph was to inform the Committee and JBC of a proposed rule change, not to indicate that it was guaranteed to be finalized as-is.

Gretchen Hammer also pointed out that the Department has held, and continues to hold, conversations with the JBC regarding the potential issues with tying Medicaid rates to Medicare rates, when Medicare has committed to fundamentally shifting the payment methodologies, specifically moving towards value-based payments. Jeff recommended that the Committee be aware of these changes and that the Committee may have to change the rate review schedule.

Regarding identifying costs for physician-administered drugs that are not reimbursed by Medicare, Kevin Martin said that it is difficult to gather cost information. The Department said that they would look into J-code information in the All Payer Claims Database (APCD).

Gretchen pointed out that, in the past, the Department has made policy changes that, upon evaluation, do not necessarily net the results that stakeholders or Department staff had predicted. Gretchen suggested a guiding principle for the rate review process could be for the Department to engage the Committee in developing evaluation plans. Gretchen also noted that evaluating the efficacy of a recommendation six months post-implementation may be too soon. The committee asked to be included in reviewing evaluation criteria for a policy or rate change, prior to an implementation of a recommendation.

Gretchen also noted that covering the costs of hard goods might be a good guiding principle. She further noted that cost of services is difficult and problematic to determine.

Regarding the document that outlined logistical considerations for altering physician-administered drugs, which the Department handed out prior to the meeting, Gretchen noted that the Department has previously sought, from the General Assembly, a targeted rate increase for certain physician-administered drugs. It was not granted.

Stakeholder Comment

Dr. Jody Ryan, from the Mental Health Center of Denver, recommended moving long-acting antipsychotic injectibles to a pharmacy benefit. Dr. Ryan said that other private payers reimburse via a pharmacy benefit methodology. He additionally said that the buy-and-bill model doesn't work for community mental health centers. Dr. Ryan said he could provide information on studies that show the improved health outcomes for long-acting anti-psychotics.

Jacob Hansmeier, from the Jefferson Center for Mental Health, spoke and agreed with Dr. Ryan. He wanted to reiterate Gretchen's comment regarding reimbursing for the costs of goods. He said that it is difficult to provide goods when you aren't reimbursed for the cost of the good.

Becky Howard, from All Health Network, also supported the move of long-acting antipsychotic injectibles to a pharmacy benefit. She also said that it is helpful to use the time in which the client comes in for an injection as a time for a brief check-in.

Deborah Profont, from Alkermes Pharmaceuticals, wanted to reiterate what she said at the last committee meeting; injectibles should be moved to a pharmacy benefit. She also stated that Alkermes has an injectable for alcohol and opioid abuse treatment that should be moved to a pharmacy benefit. She said that there are other state Medicaid agencies that reimburse these drugs via a pharmacy benefit.

Trisha Bush, representing a center for medical health, said that her organization has had difficulty with the buy and bill practice because it cannot afford to buy the minimum number of drugs required by the drug manufacturers. She recommended long-acting injectibles be moved to a pharmacy benefit.

Preliminary Recommendations

The MPRRAC made a preliminary recommendation that:

- physician-administered drugs with an Average Sales Price (ASP) should be reimbursed using "ASP Plus" pricing, that is updated on a quarterly basis for all buy and bill drugs;
- the Department investigate carving out long-acting anti-psychotic injectibles from the physician-administered drugs benefit and placing them into the pharmacy benefit; and
- for physician-administered drugs that do not have a comparable Medicare rate, the Department investigate objective ways of determining cost and reimburse at a similar rate to ASP.

8. Principles, Wrap-up, and Next Steps

Guiding Principles to be used in recommendation development so far include:

- don't reinvent the wheel (e.g., if an established rate structure exists, consider using it);
- support recommendations that work towards providing services in the least restrictive and most cost-effective environment;
- develop methodologies to address geographic differences; and
- strive to reimburse for costs of hard goods.

Committee members also began a discussion regarding process improvements, including involving the Committee more in determining to what states rates should be compared for a particular service. Gretchen Hammer noted that this recommendation might belong in the process improvement discussion that will happen in the future.

9. Meeting adjourned.