

Medicaid Provider Rate Review Advisory Committee – 2019 Recommendations – Wilson Pace, Chair

1. Durable Medical Equipment payments (DME); The MPRRAC heard from committee members and DME stakeholders as well as reviewed data from other states related to DME provider business failures. The CMS bidding process and payment limits to Medicaid programs appears to be having a major negative impact on DME providers. The MPRRAC, based on stakeholder input, believes that Colorado should seek to get ahead of the payment issue faced by many DME providers and that not doing so will impact availability of many DME items covered by the UPL process to Medicaid recipients. There are significant financial implications to the state preventing the state from just raising DME rates. There are two other activities that can be purposed:
 - a. The Department, potentially in conjunction with the Governor's office, should determine if other states have begun discussions with CMS on the impact of the current bidding process and are seeking remedies. If so, Colorado should explore joining with these states in the discussions.
 - b. Some DME payments within the UPL process currently cover both the actual device and professional services rendered in providing the device. The MPRRAC understands that the professional services component of the current bundled payments could be separated out and paid over and above the UPL DME rate. If this is possible and acceptable to CMS the Department should immediately analyzed which codes this pertains to and consider paying a separate DME and professional services fee for these codes.
2. Ambulatory Surgical Centers (ASC) - The MPRRAC reviewed provided data and heard from committee members that Medicaid recipients utilize ASC for procedures at a much lower rate than private patients. There appear to be two reasons for this: 1) the approved procedure list for ASC for Medicaid is smaller than private insurance lists; 2) the payment model of paying only for the highest service if more than one service is provided is a major disincentive to utilize ASC even for approved procedures. Committee member testimony indicates that the Department is likely paying significantly more for surgical procedures than is necessary due to these two factors. Thus, the MPRRAC recommends that the Department immediately review the list of approved procedures for Medicaid recipients compared to private recipients and consider expanding the list of procedures approved for ASC. The MPRRAC also recommends that the Department review current policy of paying only for the highest cost procedure when multiple procedures are performed at the same time and develop an alternative payment model that will allow greater access to ASC for Medicaid recipients. If the change in payments is projected to result in an overall cost savings to the Department then the new payment model should be adopted as soon as it is feasible.
3. Residential Mental Health and Drug Abuse Treatment Facilities (Residential Child Care Facilities, Psychiatric Residential Treatment Facilities, Special Connections Program): The MPRRAC reviewed Department supplied data and heard stakeholder testimony that appears to indicate that overall payments associated with these programs do not cover the cost of delivering the services. This is a basic principal of the MPRRAC related to rate reviews, that all payments should at least cover of the actual cost of the service. The MPRRAC recommends that the Department conduct a formal cost analysis based on provider submitted data. If the mean cost of providing the service is higher than the current payments then the Department should seek

changes in the payments for these services to bring them up to at least the actual cost of the service.

4. Dialysis services – the data provided to the MPRRAC indicate that dialysis services overall are reimbursed at a rate that is sufficient to provide adequate access to these services for Medicaid recipients. Per usual recommendations the Department should seek balance to payments at the individual code level through decreasing any payments over 100% of Medicare or comparison state rates to 100% of these rates and use these funds to increase payments for codes paid less than 80% of Medicare in a revenue neutral fashion.
5. Fee for Service Behavioral Health Services: The data provided to the MPRRAC indicate the fee for service behavioral health services overall are reimbursed at a rate that is sufficient to provide adequate access to these services for Medicaid recipients. Per usual recommendations, the Department should seek to balance payments at the individual code level through decreasing any payments over 100% of Medicare or comparison states to 100% of these rates and use these funds to increase payments for codes paid less than % of Medicare or comparison states in a revenue neutral fashion.