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

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Department of Health Care Policy & Financing

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Executive Summary

This report contains the work of the Colorado Department of Health Care Policy & Financing (HCPF) to review 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, which will be presented in HCPF's 2023 Rate Review Analysis Recommendation Report on November 1, 2023. **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, 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. The services under review this year are a subset of services reviewed throughout the entire three-year cycle. For each service grouping, rate benchmark comparisons, which describe (as a percentage) how Colorado Medicaid payments compare to other payers, are listed below.

Services Rate Benchmark Comparison Results			
Service	**CO as a Percent of Benchmark**	**Service**	**CO as a Percent of Benchmark**
Anesthesia	136%	Pediatric Behavioral Therapy	78.7%
Ambulatory Surgical Centers	53.5%	Dental Services	49.8%
Fee-for-Service Behavioral Health Services	94.1%		
Maternity Services	76.3%		
Abortion Services	N/A		

Table 1. Rate Benchmark Comparison Results

Surgeries Rate Benchmark Comparison Results			
Service	**CO as a Percent of Benchmark**	**Service**	**CO as a Percent of Benchmark**
Digestive System	96.4%	Integumentary System	63.5%
Musculoskeletal System	66.4%	Eye and Auditory System	95.0%
Cardiovascular System	162.4%	Other Surgeries	78.2%
Respiratory System	82.5%		

Table 2. Surgeries Rate Benchmark Comparison Results

The MPRRAC and HCPF’s recommendations conclusions in this report for each service grouping are summarized below for consideration for the November Analysis and Recommendation report.

The total anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be $143,707,976 in total funds, and $39,558,298 in General Funds.

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 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 Funds.**

HCPF Recommendations:

Ambulatory Surgical Centers (ASCs)

MPRRAC Recommendations:

- The MPRRAC recommends an increase of ASC rates to at least 80% of the benchmark.
- The anticipated fiscal impact of the MPRRAC’s recommendations is predicted to be **$5,379,889 total funds, $1,574,264 General Funds.**

HCPF Recommendations:

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Fee-for Service (FFS) Behavioral Health Services

MPRRAC Recommendations:

- Recommendation as of July 24, 2023:
  - 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.
- Recommendation as of September 29, 2023: TBD
  - MPRRAC requested additional information to be shared during the September 29, 2023 meeting with full understanding that HCPF requires their recommendations to be finalized prior to the September meeting and therefore will not influence HCPF's recommendation.
- The anticipated fiscal impact of the MPRRAC's recommendation is $0.

HCPF Recommendations:

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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 Funds.**

HCPF Recommendations:

Abortion Services

MPRRAC Recommendations:

- The MPRRAC recommends increasing rates closer to other states' Medicaid programs because the rates are only reviewed every three years, and there is an expected increase in abortion services in the upcoming years.

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- 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 $0.

HCPF Recommendations:

Dilation & Curettage)

Pediatric Behavioral Therapy (PBT)

MPRRAC Recommendations:

- The MPRRAC recommends increasing PBT rates to 100% of the benchmark for other states 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 Funds.**

HCPF Recommendations:

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Dental Services

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 Funds.**

HCPF Recommendations:

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 Funds.**

HCPF Recommendations:

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 in total funds, $1,464,171 in General Funds.**

HCPF Recommendations:

Cardiovascular System Surgeries

MPRRAC Recommendations:

- The MPRRAC recommends rebalancing all codes to 80% of the benchmark.

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- The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be **($7,723,131) in total funds, ($2,259,943) in General Funds.**

HCPF Recommendations:

Respiratory 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 **$180,879 in total funds, $52,929 in General Funds.**

HCPF Recommendations:

Integumentary 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 **$3,216,801 in total funds, $941,300 in General Funds.**

HCPF Recommendations:

Eye and Auditory Systems Surgeries

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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 **($176,581) in total funds, ($51,671) in General Funds.**

HCPF Recommendations:

Other 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 **$1,809,649 in total funds, $529,540 in General Funds.**

HCPF Recommendations:

Co-Surgery

MPRRAC Recommendations:

- The MPRRAC did not receive data on Co-Surgery, therefore did not feel comfortable making a recommendation.

HCPF Recommendations:

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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.

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 improving 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.

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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., some vaccine & immunization 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, impeding member access; as such, 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.

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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 – FY2022.
- Total Members Utilizing Services – FY2022.
- Year-over-year Change in Members Utilizing Services – FY2021 – FY2022
- Total Active Providers – FY2022.
- Year-over-year Change in Rendering Providers – FY2021 – FY2022

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 FY2022 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. HCPF utilizes Medicare rates for comparison for reasons including:

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- 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 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. HCPF is now reviewing all enrolled specialists to identify providers not seeing enough Medicaid members. For the purposes of this current report, and said another way, 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.

• 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:

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- 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 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.

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Anesthesia

Service Description

The anesthesia service grouping consists of 250 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 FY2022	$35,662,790
Total Members Utilizing Services in FY2022	94,532
FY2022 Over FY2021 Change in Members Utilizing Services	3.9%
Total Active Providers FY2022	1,764
FY2022 Over FY2021 Change in Active Providers	2.3%

Table 3. Anesthesia expenditure and utilization data (FY2022).

Rate Comparison Analysis

On average, Colorado Medicaid payments for anesthesia services are estimated at 136.0% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

Anesthesia Rate Benchmark Comparison		
Colorado Repriced	**Repriced**	**Rate Benchmark Comparison**
$35,662,790	$26,225,236	136.0%

Table 4. Comparison of Colorado Medicaid anesthesia service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be ($9,437,554) in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 250 procedure codes analyzed in this service grouping, 248 were compared to Medicare (99%), and 2 did not have comparable Medicare rates. Individual rate ratios for anesthesia services were 17.2% - 266.8%.

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 B for Stakeholder Feedback.

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● 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	$ 2,465,752	$ 1,829,551	134.8%
2	01967	ANESTH/ANALG VAG DELIVERY	$ 2,212,667	$ 2,384,645	$ 1,783,062	133.7%
3	00731	ANES UPR GI NDSC PX NOS	$ 2,227,284	$ 2,291,782	$ 1,700,708	134.8%
4	00790	ANESTH SURG UPPER ABDOMEN	$ 2,011,803	$ 2,061,510	$ 1,528,683	134.9%
5	00170	ANESTH PROCEDURE ON MOUTH	$ 1,773,391	$ 1,818,772	$ 1,348,952	134.8%
6	01961	ANESTH CS DELIVERY	$ 1,156,876	$ 1,188,030	$ 817,767	145.3%
7	00670	ANESTH SPINE CORD SURGERY	$ 1,076,582	$ 1,102,180	$ 817,220	134.9%
8	01480	ANESTH LOWER LEG BONE SURG	$ 983,851	$ 1,010,285	$ 749,495	134.8%
9	01922	ANESTH CAT OR MRI SCAN	$ 967,917	$ 1,000,752	$ 743,249	134.6%
10	00811	ANES LWR INTST NDSC NOS	$ 938,046	$ 962,370	$ 713,800	134.8%
Totals			$ 15,743,749	$ 16,286,079	$ 12,032,486	

Table 5. Top 10 codes utilized for anesthesia services (FY2022).

No outliers are identified in this service category.

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.

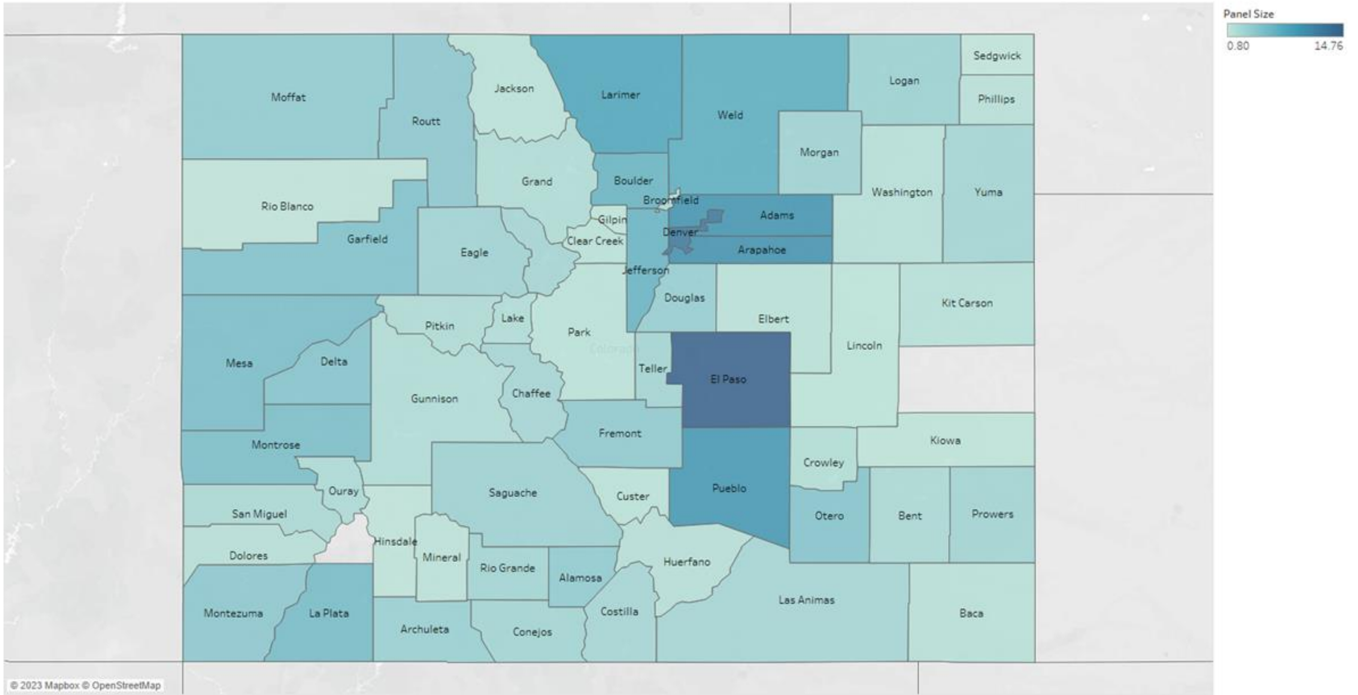

Figure 2. Anesthesia utilizer to provider ratio per county (FY2022).

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 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) in total funds, ($2,896,344) in General Funds.

HCPF Recommendations

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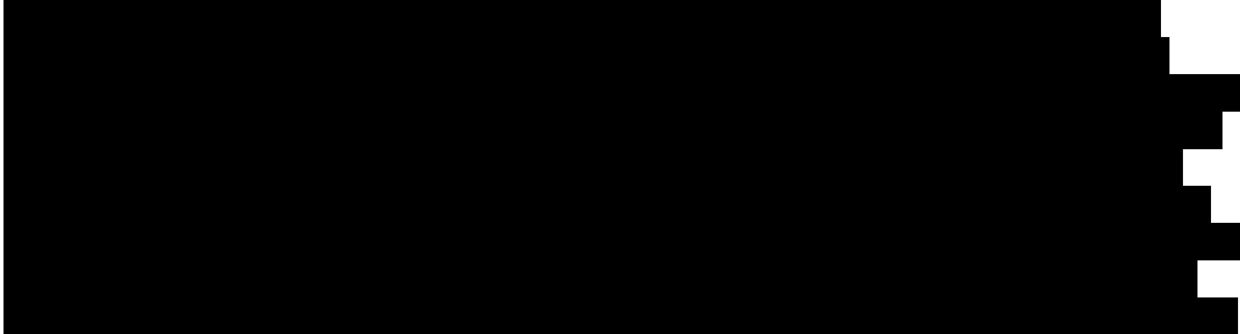
Policy Justification



Ambulatory Surgical Centers

Service Description

The ambulatory surgical centers (ASCs) service grouping comprises 2,686 procedure codes. 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 FY2022	$13,381,112
Total Members Utilizing Services in FY2022	21,890
FY2022 Over FY2021 Change in Members Utilizing Services	9.4%
Total Active Providers FY2022	305
FY2022 Over FY2021 Change in Active Providers	12.1%

Table 6. Ambulatory Surgical Centers expenditure and utilization data (FY2022).

Rate Comparison Analysis

On average, Colorado Medicaid payments for ASC services are estimated at 51.9% 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 7. Comparison of Colorado Medicaid Ambulatory Surgical Centers service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $9,432,909 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 2,686 procedure codes analyzed in this service grouping, 2,424 were compared to Medicare

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(90%), and 262 did not have comparable Medicare rates. Individual rate ratios for ASCs services were 25.4% - 77.2%.

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 B 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			
Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A01	$ 2,063,865	$ 3,627,303	56.9%
A02	$ 3,792,552	$ 5,700,607	66.5%
A03	$ 834,843	$ 3,187,907	26.2%
A04	$ 603,662	$ 1,702,973	35.4%
A05	$ 595,826	$ 1,605,658	37.1%
A06	$ 250,098	$ 738,342	33.9%
A07	$ 253,733	$ 611,368	41.5%
A08	$ 1,629,422	$ 2,050,309	79.5%
A09	$ 383,337	$ 505,154	75.9%
A10	$ 424,854	$ 535,480	79.3%
A11	$ -	$ -	0.0%
Total	**$ 10,832,192**	**$ 20,265,101**	**53.5%**

Repriced Medicare - Multiple Procedure Discount			
Assigned Rate Type	Medicaid Repriced - TPL	Medicare Repriced	% of Benchmark
A01	$ 2,063,865	$ 4,306,859	47.9%
A02	$ 3,792,552	$ 7,054,236	53.8%
A03	$ 834,843	$ 3,941,267	21.2%
A04	$ 603,662	$ 1,961,016	30.8%
A05	$ 595,826	$ 1,707,423	34.9%
A06	$ 250,098	$ 781,022	32.0%
A07	$ 253,733	$ 628,474	40.4%
A08	$ 1,629,422	$ 2,068,211	78.8%
A09	$ 383,337	$ 524,014	73.2%
A10	$ 424,854	$ 565,387	75.1%
A11	$ -	$ -	0.0%
Total	**$ 10,832,192**	**$ 23,537,908**	**46.0%**

Table 8. 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. (FY2022).

No outliers are identified in this service category.

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.

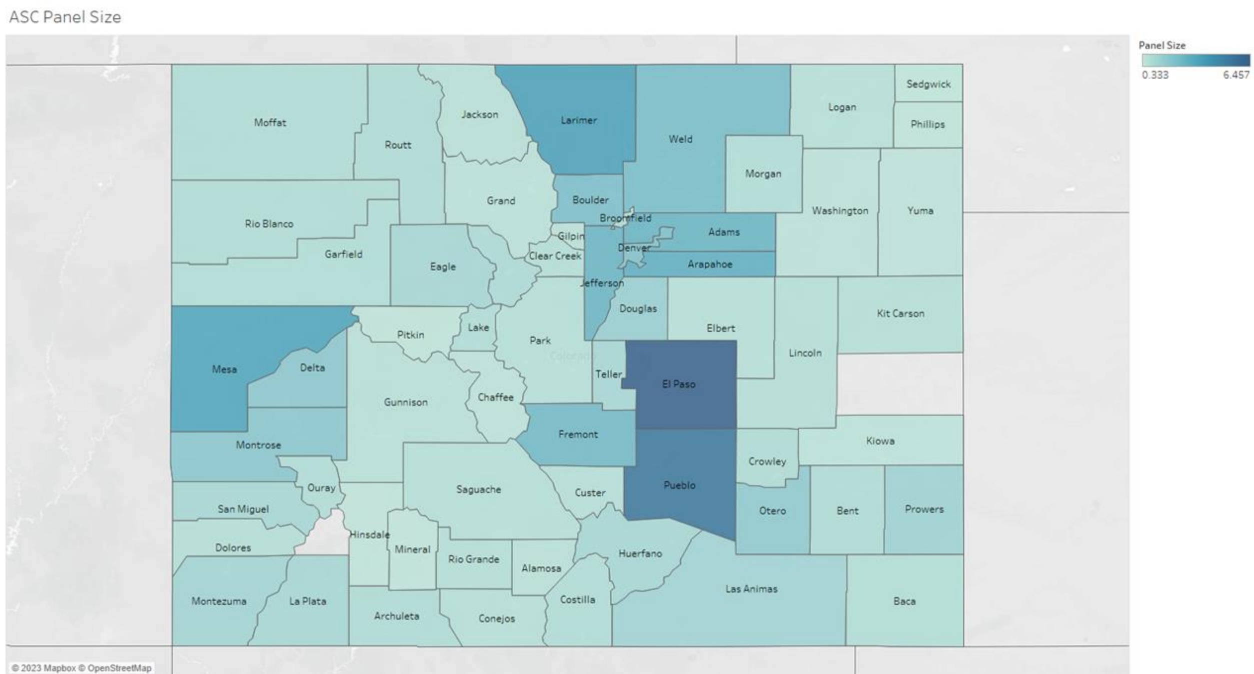

Figure 3. ASC utilizer to provider ratio per county (FY2022).

- ## 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 54%
  - The anticipated fiscal impact of the MPRRAC's recommendations is predicted to be $5,379,889 in total funds, $1,574,264 in General Funds.

- ## HCPF Recommendations

COLORADO Department of Health Care Policy & Financing HCPF

Policy Justification

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. These outpatient mental health and substance use disorder services (SUD) (7 SUD related procedure codes are not reviewed this year) are not reimbursed by Regional Accountable Entities (RAEs) due to a diagnosis not covered by the RAE, such as autism; for procedures not covered by the RAE, such as developmental testing; or for the member not being enrolled in a RAE, such as Qualified Medicare Beneficiary (QMB)/Specified Low-income Medicare Beneficiary (SLMB) eligibility or members in between attribution spans. 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 FY2022	$18,734,736
Total Members Utilizing Services in FY2022	112,683
FY2022 Over FY2021 Change in Members Utilizing Services	8.8%
Total Active Providers FY2022	3,699
FY2022 Over FY2021 Change in Active Providers	12.5%

Table 9. Fee-for-Service Behavioral Health Services expenditure and utilization data.

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● Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS Behavioral Health Services are estimated at 94.1% 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
$17,621,454	$18,732,206	94.1%

Table 10. Comparison of Colorado Medicaid Fee-for-Service Behavioral Health Service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $1,110,752 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 31 procedure codes analyzed in this service grouping, 30 were compared to Medicare (97%), and 1 did not have comparable Medicare rates. 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 B 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	$ 1,713,369	$ 1,734,130	$ 1,713,369	100.0%
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 11. Top 10 codes utilized for Fee-for-Service Behavioral Health services (FY2022).

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 12. Outlier for Fee-for-Service Behavioral Health services codes (FY2022).

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.

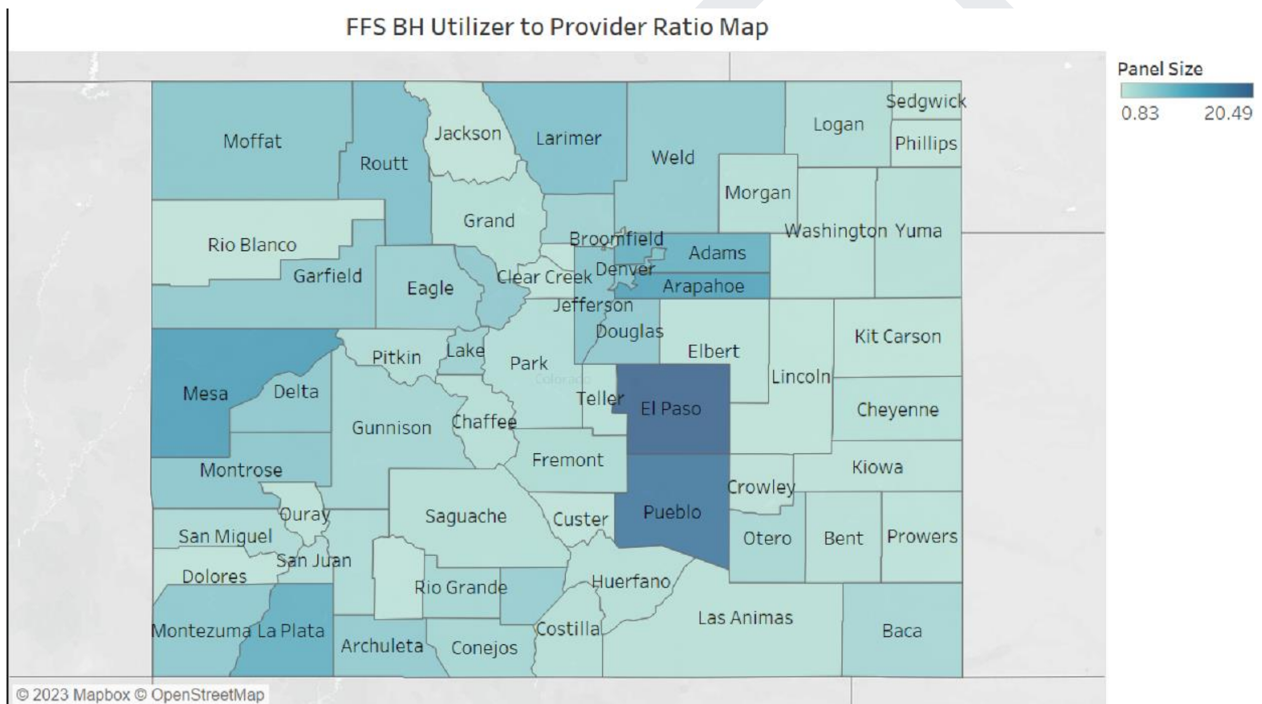

Figure 4. Fee-for-Service Behavioral Health services utilizer to provider ratio per county (FY2022).

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- ## MPRRAC Recommendations
  - Recommendation as of July 24, 2023:
    - 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

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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.

- Recommendation as of September 29, 2023:
  - MPRRAC requested additional information to be shared during the September 29, 2023 meeting with full understanding that HCPF requires their recommendations to be finalized prior to the September meeting and therefore will not influence HCPF's recommendation.

- **HCPF Recommendations**

- **Policy Justification**

DRAFT

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 the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This benefit was created as a benefit 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 FY2022	$124,914,666
Total Members Utilizing Services in FY2022	5,371
FY2022 Over FY2021 Change in Members Utilizing Services	18.1%
Total Active Providers FY2022	820
FY2022 Over FY2021 Change in Active Providers	24.1%

Table 17. 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 18. Comparison of Colorado Medicaid Pediatric Behavioral Therapy service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $34,281,532 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. 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 17.9% - 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 B 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.

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HCPF conducted a rate comparison analysis with cost of living adjustment considered. There were 7 states selected for the first round PBT analysis as: 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 finally 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, Oregeon, 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

			Other States Rates											
Procedure Code	Procedure Description	CO HealthFirst	FL	MA	MD	NC	NE	NV	OR	TX	UT	WA	Other States Average	Percent
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 19.Pediatric behavioral health codes compared to 10 other states adjusted for cost of living. (FY2022).

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

			Colorado Tricare			
Procedure Code	Procedure Description	CO HealthFirst	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 20. Pediatric behavioral health codes compared to Colorado Tricare rates. (FY2022).

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.

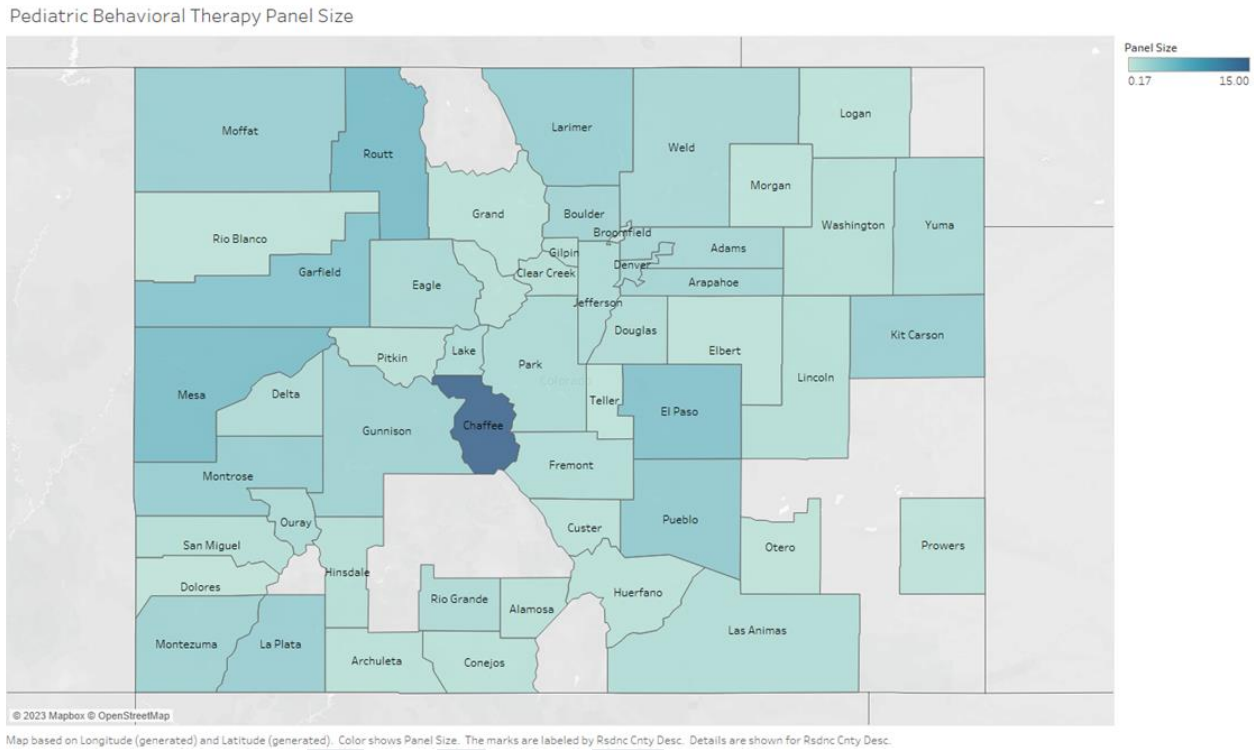

Figure 6. Pediatric behavioral health utilizer to provider ratio per county (FY2022)

- ## MPRRAC Recommendations

  - The MPRRAC recommends increasing PBT rates to 100% of the benchmark for other states 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 in total funds, $17,140,766 in General Funds.

- ## HCPF Recommendations

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- **Policy Justification**

Maternity Services

Service Description

The maternity service grouping comprises 44 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 FY2022	$25,186,891
Total Members Utilizing Services in FY2022	23,025
FY2022 Over FY2021 Change in Members Utilizing Services	.15%
Total Active Providers FY2022	1,382
FY2022 Over FY2021 Change in Active Providers	3.4%

Table 13. Maternity services expenditure and utilization data.

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● 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	$37,208,926	76.3%

Table 14. Comparison of Colorado Maternity Service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $8,830,266 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 44 procedure codes analyzed in this service grouping, 42 were compared to Medicare (96%), and 2 did not have comparable Medicare rates. 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 B 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 97.62% 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.

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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	$ 706,549	68.6%
9	59515	CESAREAN DELIVERY	$ 390,686	$ 410,714	$ 470,089	87.4%
10	59425	ANTEPARTUM CARE ONLY	$ 244,946	$ 257,341	$ 367,371	70.0%

Table 15. Top 10 codes utilized for maternity services (FY2022).

HCPF identified one 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%

Table 16. Outliers for maternity service codes (FY2022).

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.

Maternity Panel Size

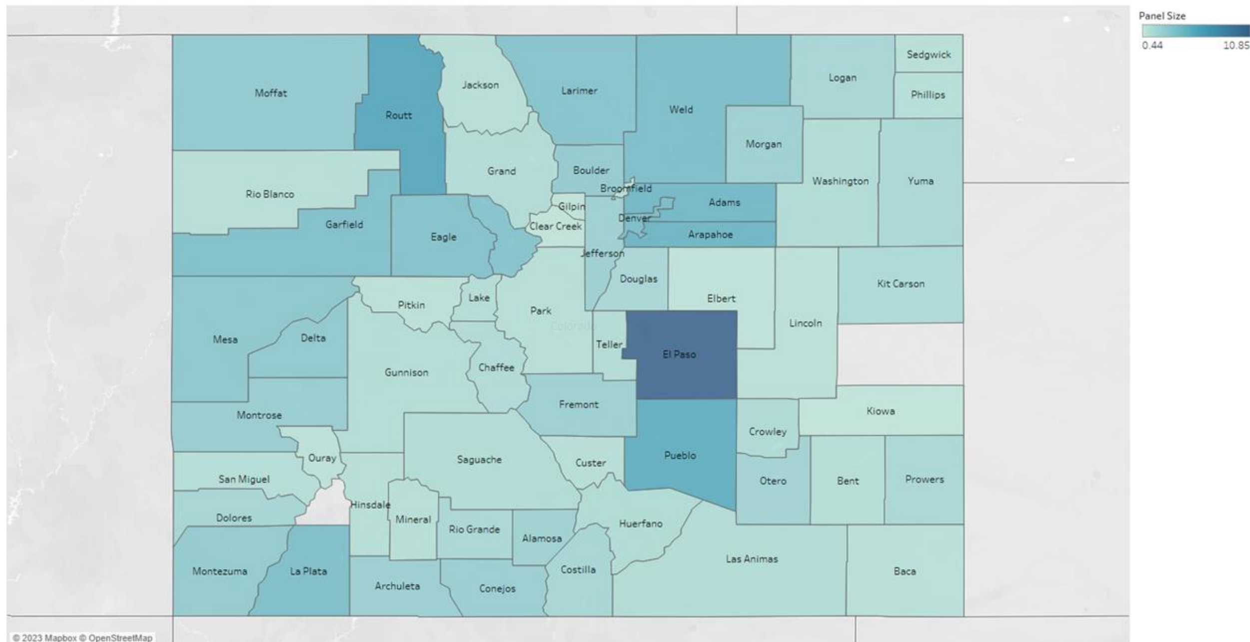

Figure 5. Maternity services utilizer to provider ratio per county (FY2022)

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 in total funds, $4,471,123 in General Funds.

HCPF Recommendations

Policy Justification

Abortion Services

Service Description

The maternity service grouping comprises 1 procedure code. 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 had no utilization: 59855, 59841, 59850, 59851, 59852, 59856, 59857.

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 B 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 state's (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, and there is an expected increase in abortion services in the upcoming 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

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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

Dilation & Curettage)

Policy Justification

Dental Services

Service Description

The dental service grouping comprises 466 procedure codes. Historically, Colorado Medicaid covered dental services for children; Colorado Medicaid began covering dental services for adults in 2013. The adult dental benefit provides eligible Colorado Medicaid members up to $1,500 in dental services per state fiscal year. 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.

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Dental services were previously reviewed in the 2018 Medicaid Provider Rate Review Analysis Report.

Dental Services Statistics	
Total Adjusted Expenditures FY2022	$276,056,155
Total Members Utilizing Services in FY2022	514,162
FY2022 Over FY2021 Change in Members Utilizing Services	7.3%
Total Active Providers FY2022	1,785
FY2022 Over FY2021 Change in Active Providers	3.5%

Table 21. 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.

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

Table 22. Comparison of Colorado Dental Service payments to those of other payers, expressed as a percentage (FY2022).

Of the 466 procedure codes analyzed in this service grouping, 151 were compared to the ADA Survey, and 315 did not have comparable ADA Survey rates.

- ## 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 B 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.

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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 23. Top 10 codes utilized for dental services (FY2022).

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 24 . Outliers for dental services codes (FY2022).

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.

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Department of Health Care
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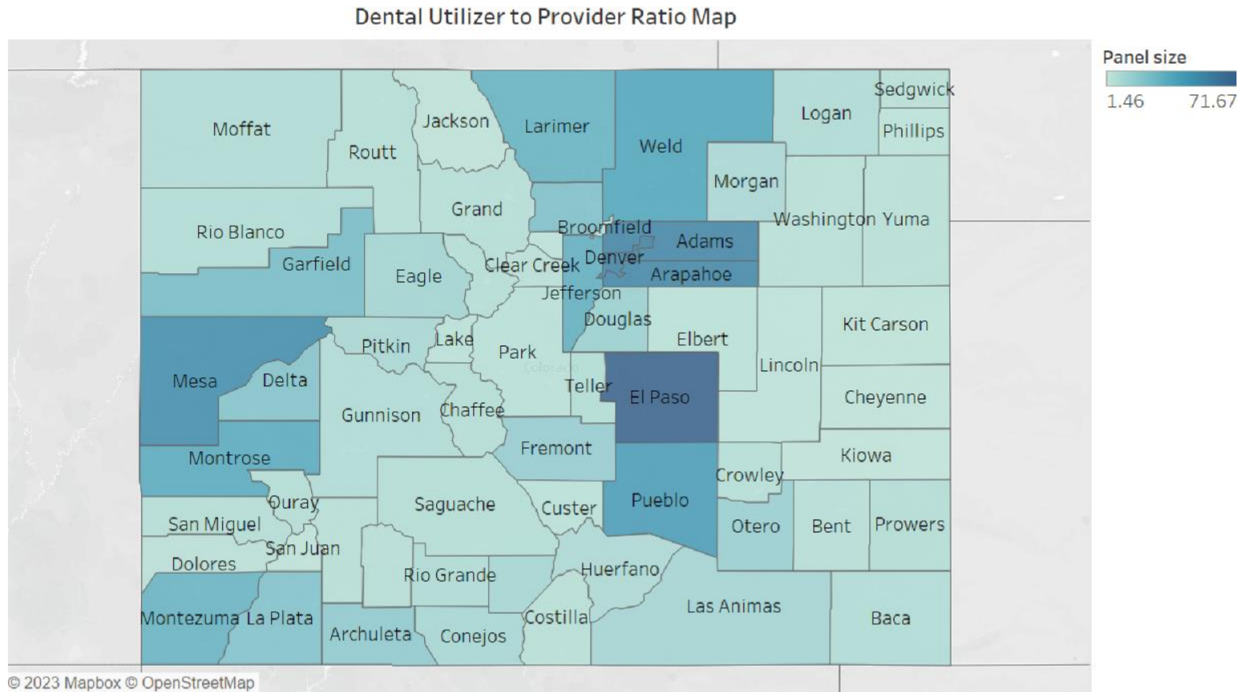
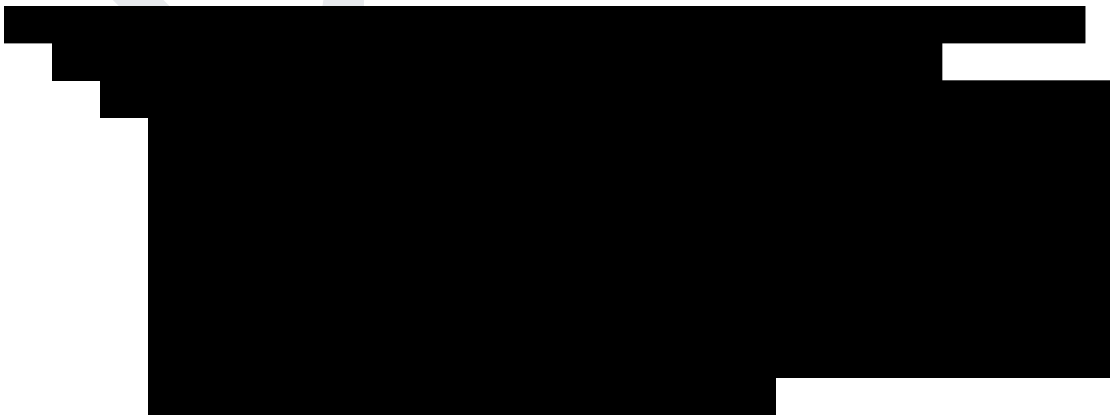


Figure 7. Dental services utilizer to provider ratio per county (FY2022)

- **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 in total funds, $19,015,624 in General Funds.
- **HCPF Recommendations**



- **Policy Justification**

- ## 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

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Surgeries Statistics	
Total Adjusted Expenditures FY2022	$108,963,932
Total Members Utilizing Services in FY2022	240,292
FY2022 Over FY2021 Change in Members Utilizing Services	-3.9%
Total Active Providers FY2022	14,943
FY2022 Over FY2021 Change in Active Providers	3.4%

Table 25. Surgeries total expenditure and utilization data (FY2022).

The surgeries service grouping comprises 4,048 procedure codes. Of the 4,048 procedure codes analyzed in this service grouping, 3,946 were compared to Medicare (97%), and 102 did not have comparable Medicare rates.

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

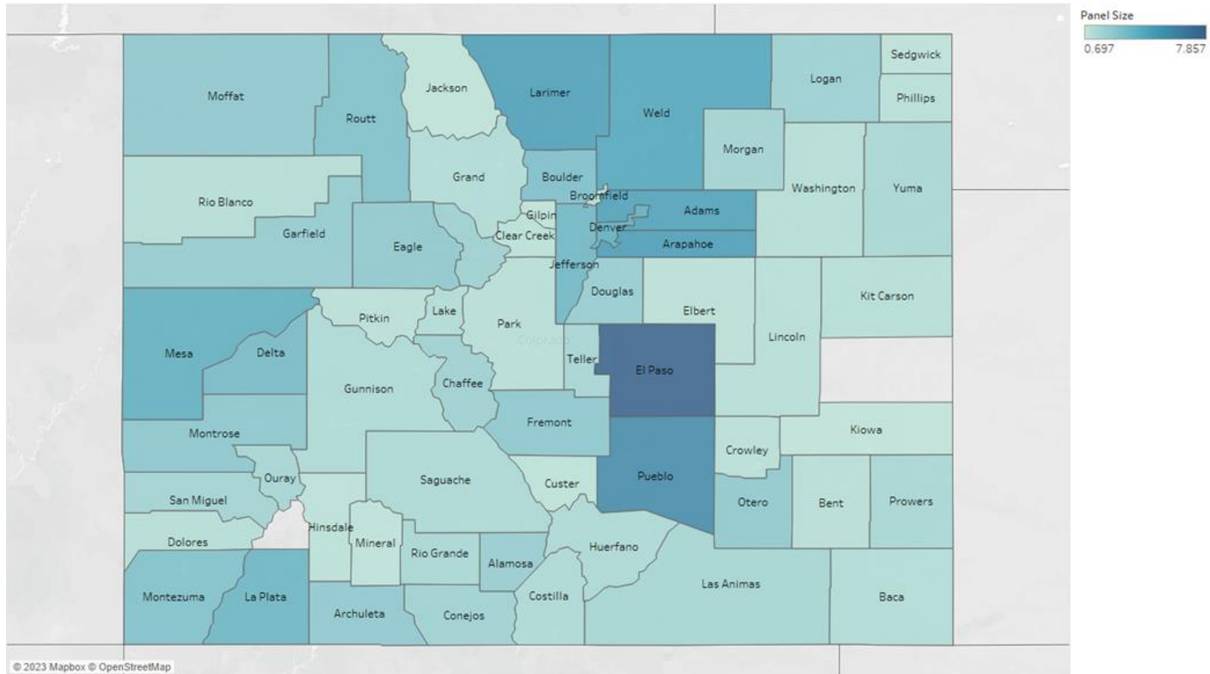

Figure 8. Surgeries (all service categories) utilizer to provider ratio per county (FY2022)

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 9. Outliers for surgeries (all service categories) over 140% (FY2022).

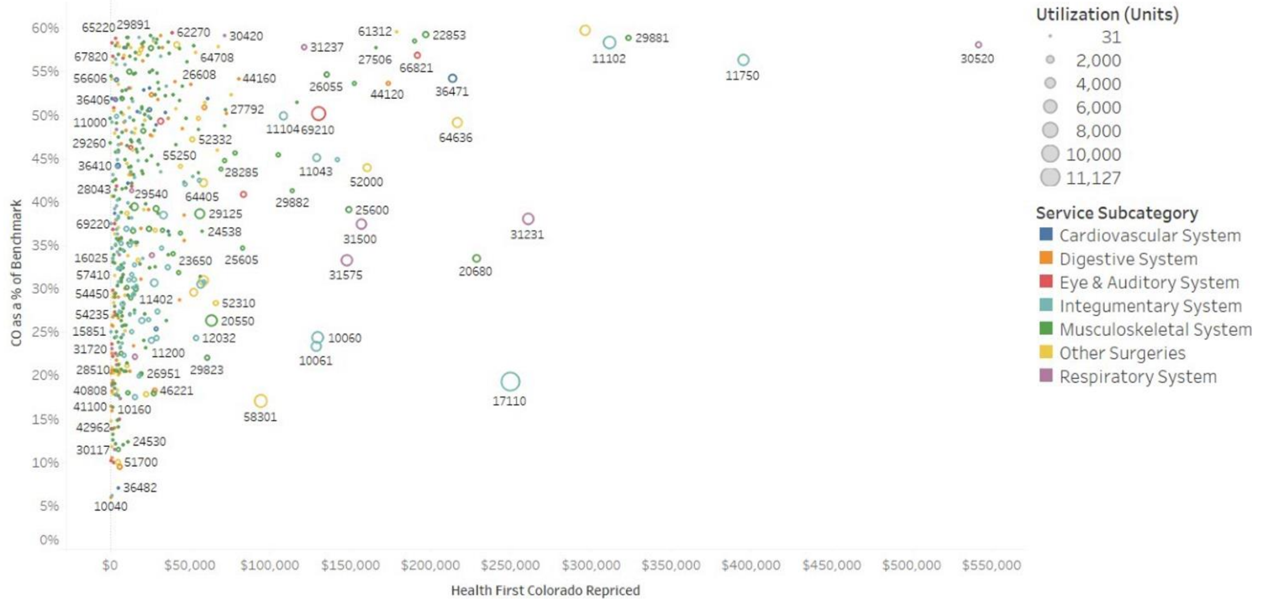

Figure 10. Outliers for surgeries (all service categories) under 60% (FY2022).

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 26. Top 10 codes utilized for surgeries (all service categories) (FY2022).

• Surgeries – Digestive System

• Service Description

The digestive system surgery service grouping comprises 622 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 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 27. Comparison of Colorado Medicaid digestive system surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $813,045 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 622 procedure codes analyzed in this service grouping, 615 were compared to Medicare (99%), and 7 did not have comparable Medicare rates. 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 B 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 158 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.

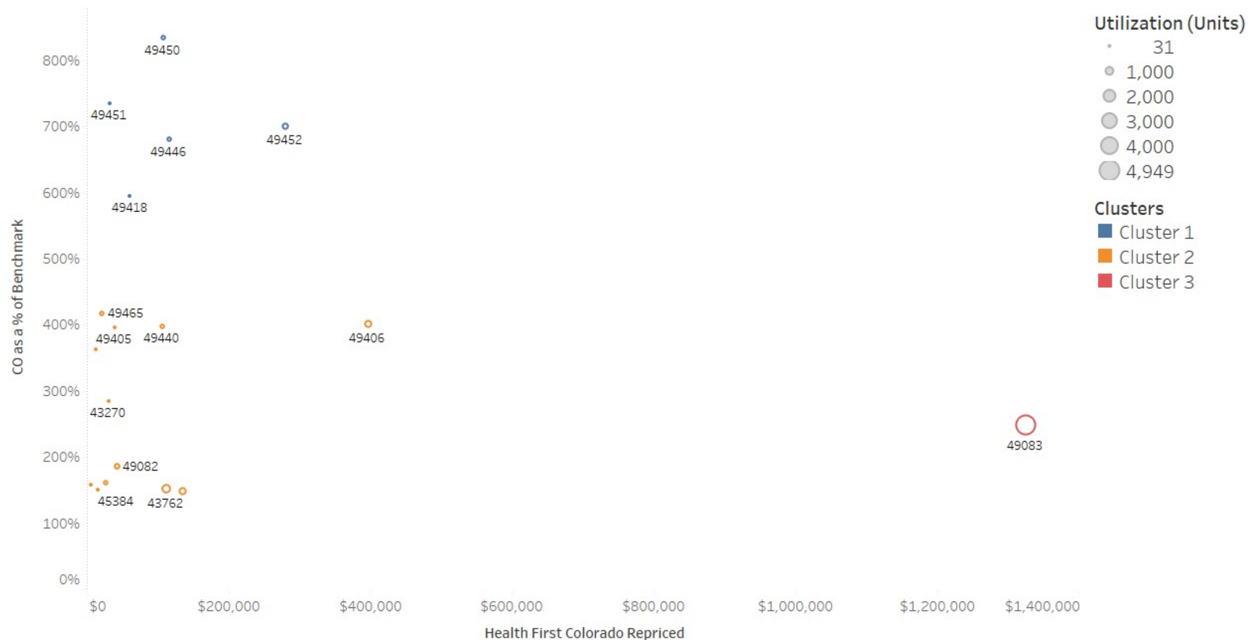

Figure 11. Outliers for digestive surgeries over 140% (FY2022).

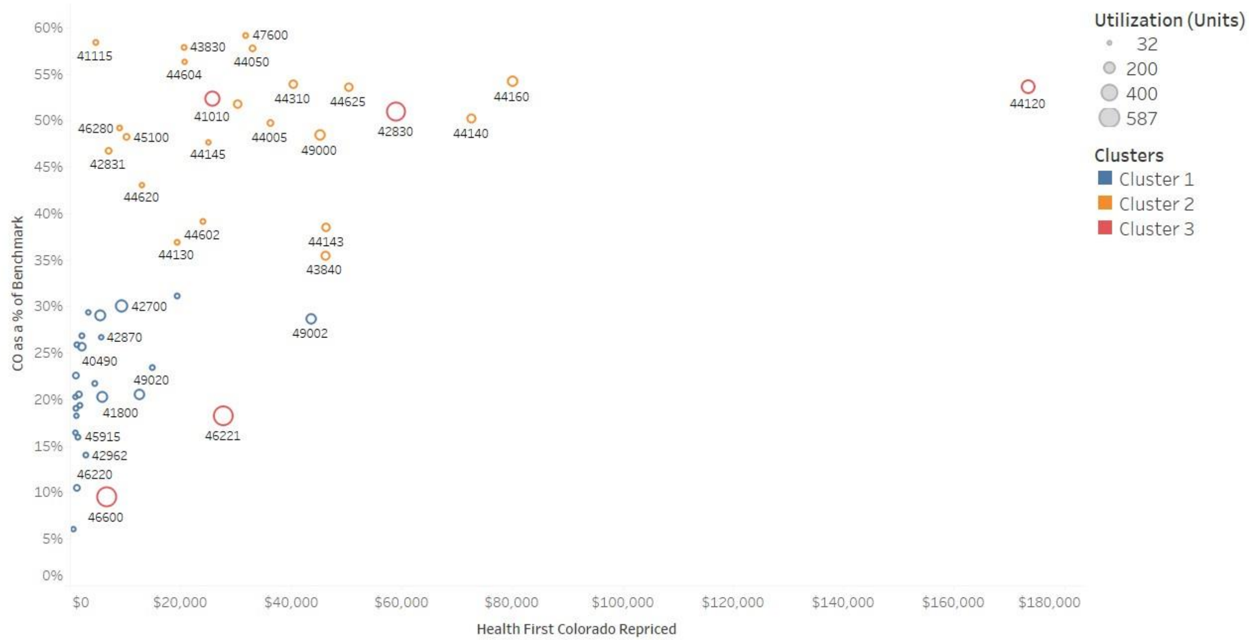

Figure 12. Outliers for digestive surgeries under 60% (FY2022).

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.

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Surgery Panel Size - Digestive Systems

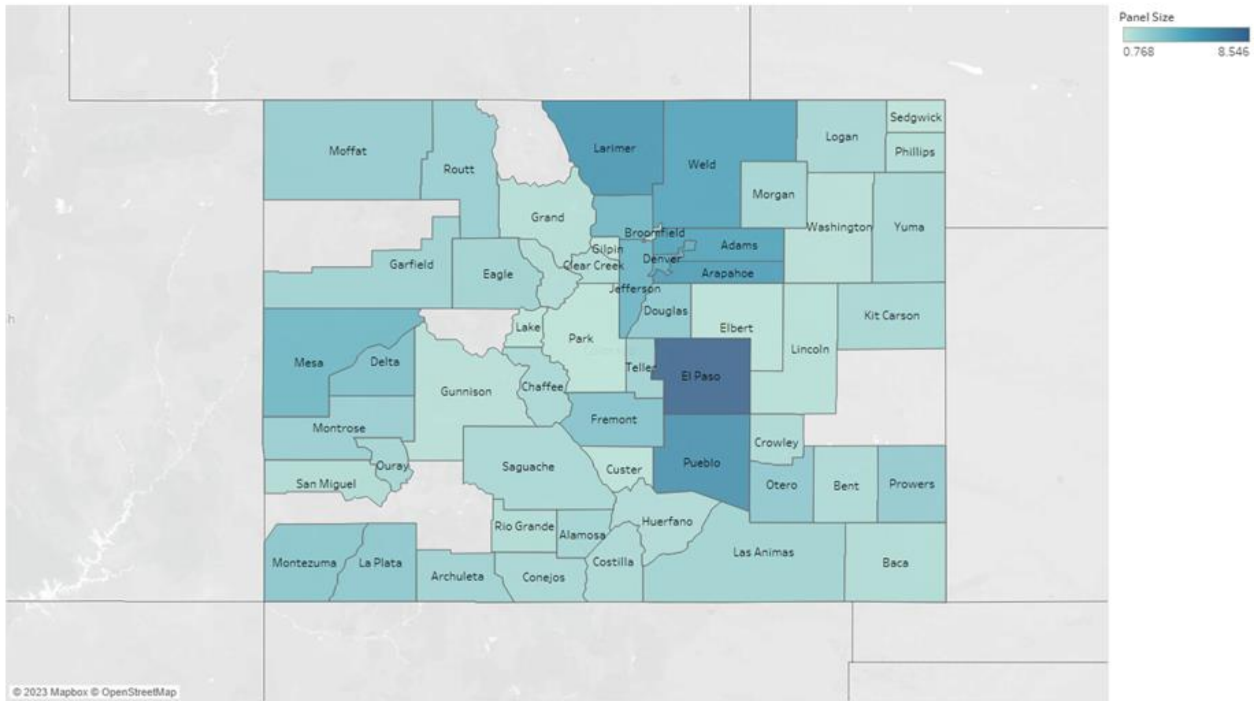

Figure 13. Digestive surgeries utilizer to provider ratio per county (FY2022)

- ## 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) in total funds,($423,461) in General Funds.

- ## HCPF Recommendations

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Policy Justification

Surgeries – Musculoskeletal System

Service Description

The musculoskeletal system surgery service grouping comprises 1,246 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 28. Comparison of Colorado Medicaid Musculoskeletal System Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $12,389,119 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 1,246 procedure codes analyzed in this service grouping, 1,240 were compared to Medicare (99%), and 6 did not have comparable Medicare rates. Individual rate ratios for Musculoskeletal System Surgery services were 6.2% - 1,734.1%.

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 B 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.

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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.

Figure 14. Outliers for musculoskeletal surgeries over 140% (FY2022).

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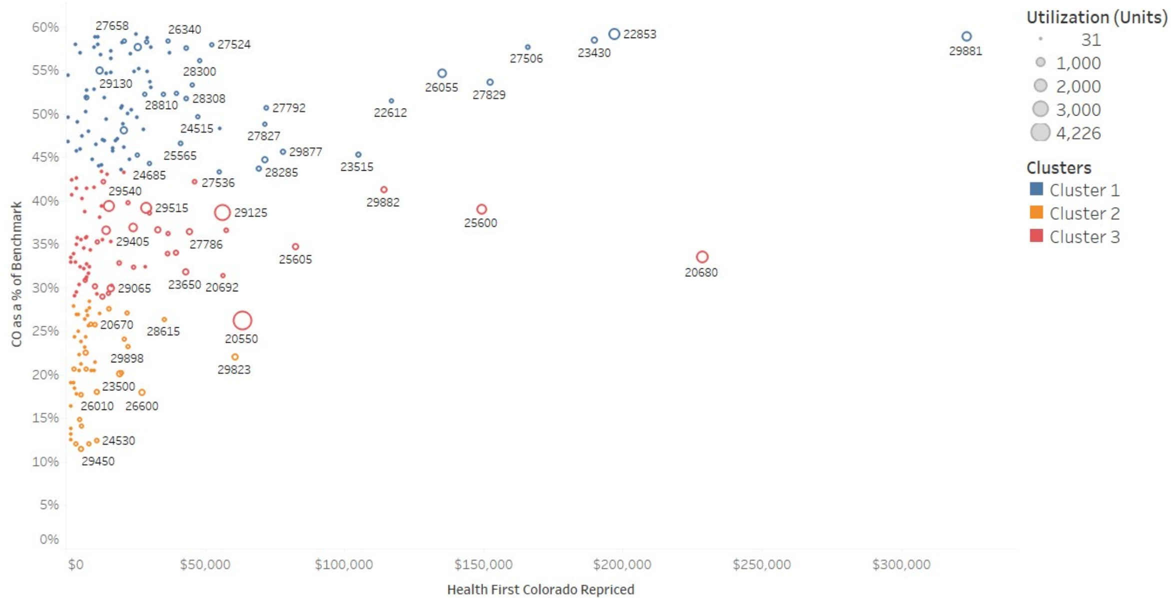

Figure 15. Outliers for musculoskeletal surgeries under 60% (FY2022).

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.

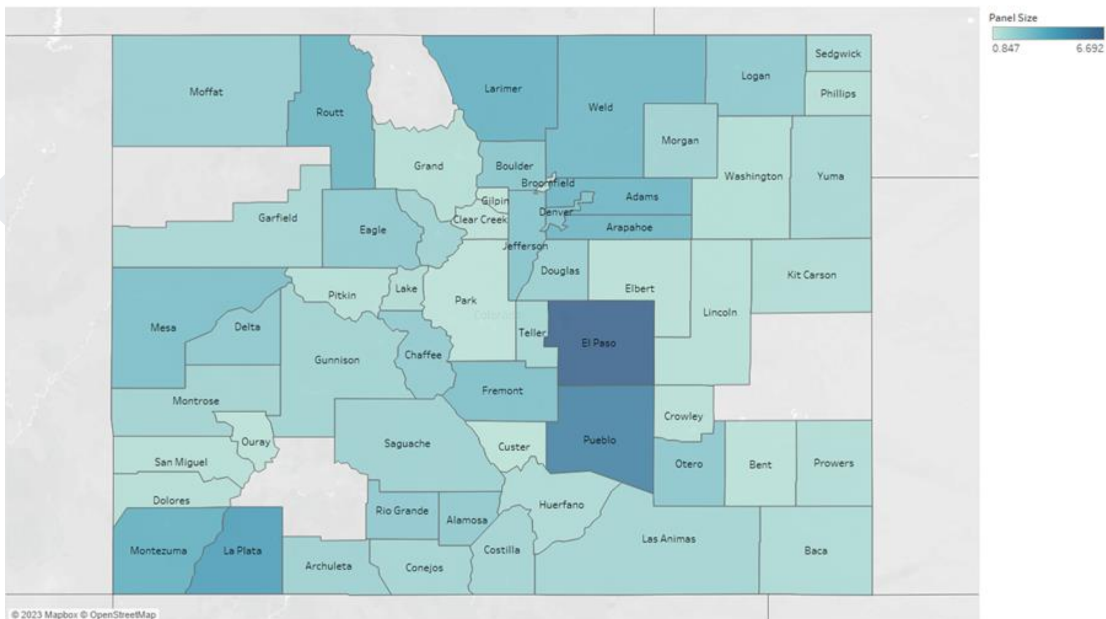

Figure 16. Musculoskeletal surgeries utilizer to provider ratio per county (FY2022).

- **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 in total funds, $1,464,171 in General Funds.

- **HCPF Recommendations**

- **Policy Justification**

Surgeries – Cardiovascular System

Service Description

The cardiovascular system surgery service grouping comprises 453 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 29. Comparison of Colorado Medicaid Cardiovascular System Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be ($6,793,707) in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 453 procedure codes analyzed in this service grouping, 445 were compared to Medicare

(98%), and 8 did not have comparable Medicare rates. Individual rate ratios for Cardiovascular System Surgery services were 5.6% - 1,302.4%.

● 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 B 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.

Figure 17. Outliers for cardiovascular surgeries over 140% (FY2022).

Figure 18. Outliers for cardiovascular surgeries under 60% (FY2022).

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.

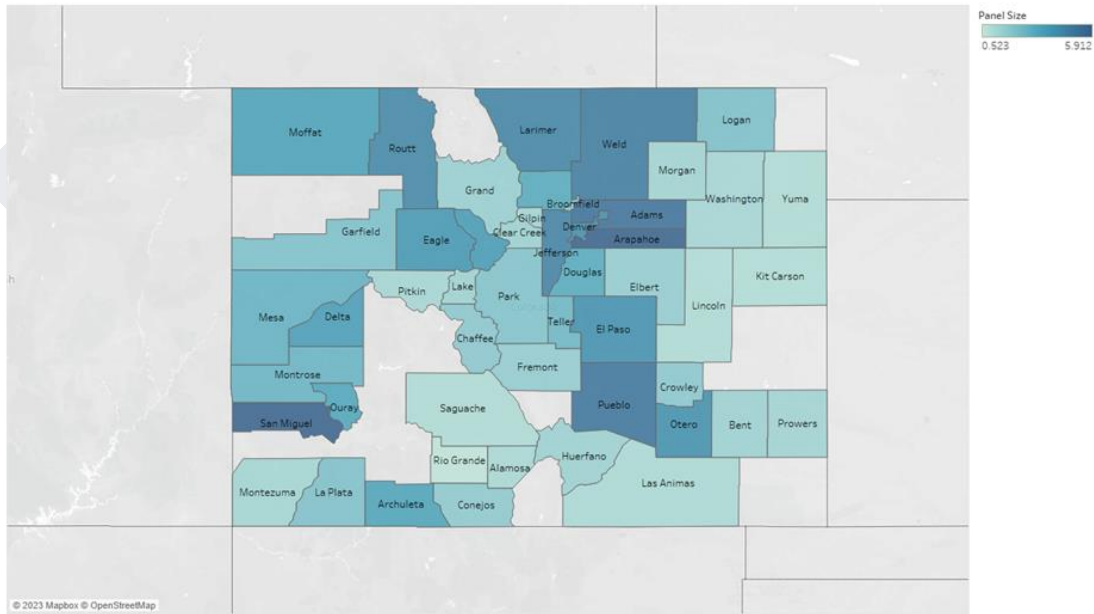

Figure 19. Cardiovascular surgeries utilizer to provider ratio per county (FY2022).

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- **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 ($7,723,131) in total funds, ($2,259,943) in General Funds.

- **HCPF Recommendations**

- **Policy Justification**

Surgeries – Respiratory System

Service Description

The respiratory system surgery service grouping comprises 203 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 30. Comparison of Colorado Medicaid Respiratory System Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $1,065,677 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 203 procedure codes analyzed in this service grouping, 202 were compared to Medicare (99%), and 1 did not have comparable Medicare rates. 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 B 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.

Figure 20. Outliers for respiratory surgeries over 140% (FY2022).

Figure 21. Outliers for respiratory surgeries under 60% (FY2022).

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.

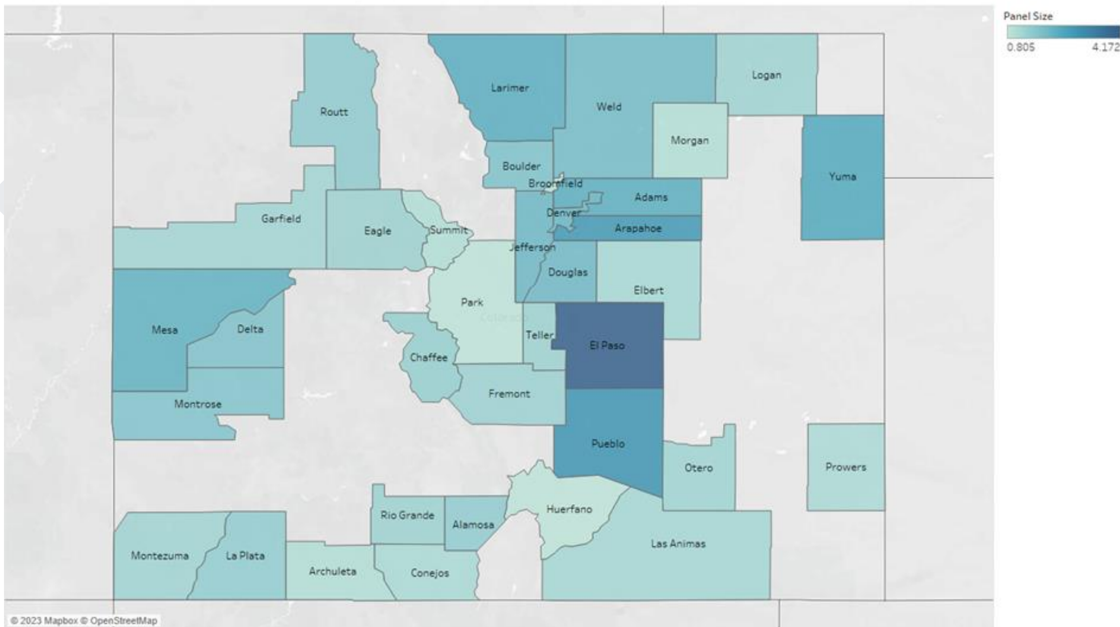

Figure 22. Respiratory surgeries utilizer to provider ratio per county (FY2022).

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 $180,879 in total funds, $52,929 in General Funds.

HCPF Recommendations

Surgeries – Integumentary System

Service Description

The integumentary system surgery service grouping comprises 336 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 31. Comparison of Colorado Medicaid Integumentary System Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $5,918,956 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 336 procedure codes analyzed in this service grouping, 330 were compared to Medicare (98%), and 6 did not have comparable Medicare rates. 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.

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- ## Stakeholder Feedback

See Appendix B 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.

Figure 23. Outliers for integumentary surgeries over 140% (FY2022).

Integumentary Surgery Outliers Under 60%

Figure 24. Outliers for integumentary surgeries under 60% (FY2022).

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

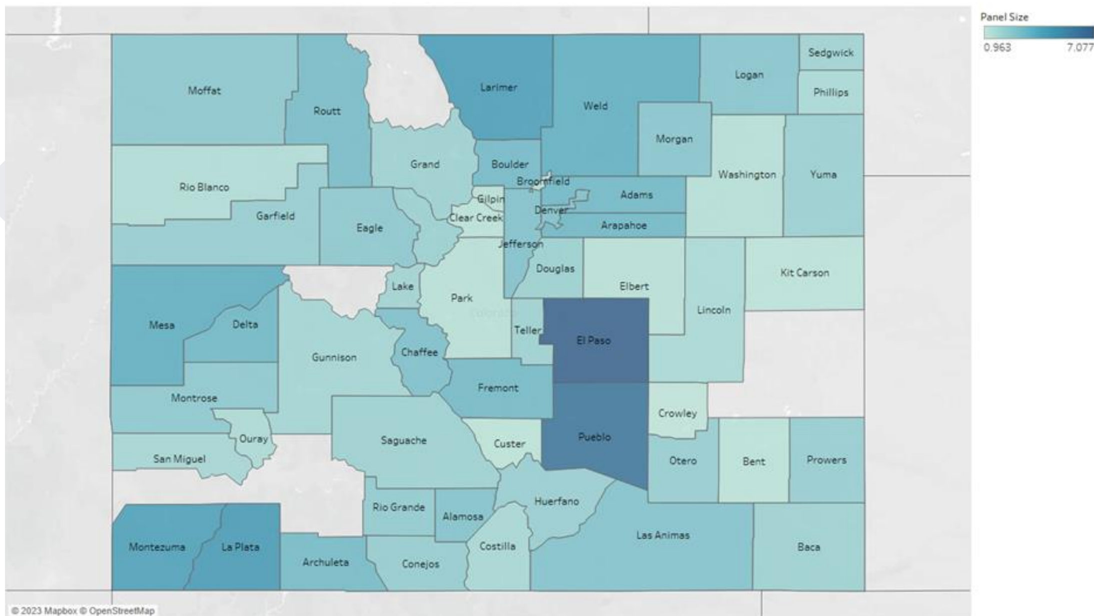

Figure 25. Integumentary surgeries utilizer to provider ratio per county (FY2022).

- **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 $3,216,801 in total funds, $941,300 in General Funds.

- **HCPF Recommendations**

- **Policy Justification**

Surgeries – Eye and Auditory System

Service Description

The eye and auditory system surgery service grouping comprises 253 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 32. Comparison of Colorado Medicaid Eye and Auditory System Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $445,601 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 253 procedure codes analyzed in this service grouping, 249 were compared to Medicare (98%), and 4

did not have comparable Medicare rates. 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 B 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 26. Outliers for eye and auditory surgeries over 140% (FY2022).

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Eye and Auditory Surgery Outliers Under 60%

Figure 27. Outliers for eye and auditory surgeries under 60% (FY2022).

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

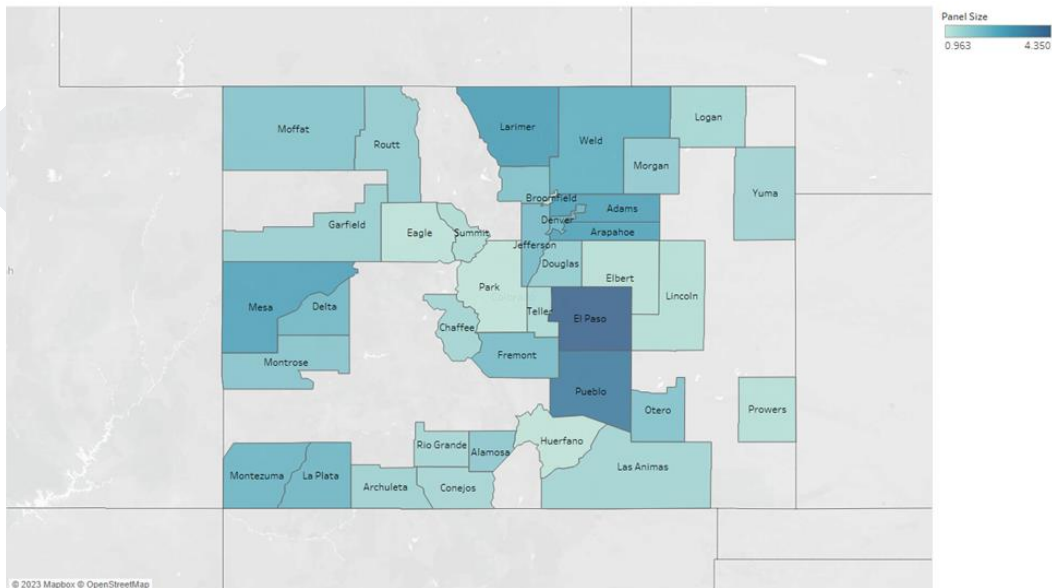

Figure 28. Eye and auditory surgeries utilizer to provider ratio per county (FY2022).

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- **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 ($176,581) in total funds, ($51,671) in General Funds.

- **HCPF Recommendations**

- **Policy Justification**

Surgeries - Other

Service Description

The other surgery service grouping comprises 893 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 33. Comparison of Colorado Medicaid Other Surgery service payments to those of other payers, expressed as a percentage (FY2022).

The estimated fiscal impact to Colorado Medicaid would be $5,918,013 in total funds if Colorado had reimbursed at 100% of the benchmark in FY2022. Of the 893 procedure codes analyzed in this service grouping, 883 were compared to Medicare

(99%), and 10 did not have comparable Medicare rates. Individual rate ratios for Other Surgery services were 2.5% - 1,335.2%.

● 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 B 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.

Figure 29. Outliers for other surgeries over 140% (FY2022).

Figure 30. Outliers for other surgeries under 60% (FY2022).

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.

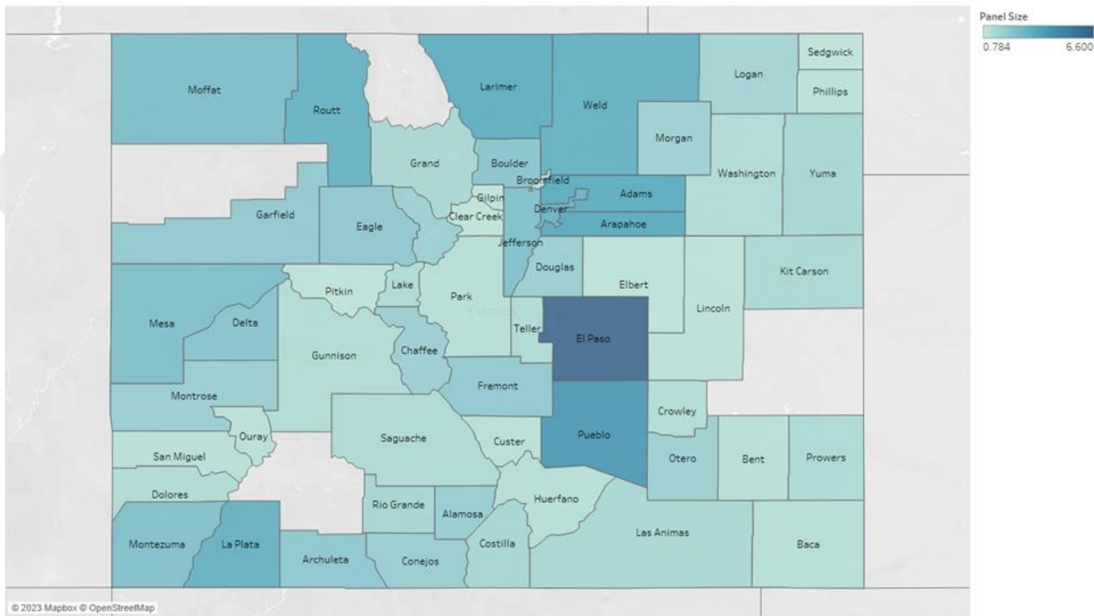

Figure 31. Other surgeries utilizer to provider ratio per county (FY2022).

- **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 $1,809,649 in total funds,$529,540 in General Funds.

- **HCPF Recommendations**

- **Policy Justification**

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.

- **MPRRAC Recommendation**
  - The MPRRAC did not receive data on Co-Surgery, therefore did not feel comfortable making a recommendation.

- **HCPF Recommendation**

- **Policy Justification**

DRAFT