



RATE REVIEW WORKING RECOMMENDATIONS

AMBULATORY SURGICAL CENTERS (ASC)

ANALYSIS RESULTS¹

- Analyses suggest that ASC payments at 63.95% of the benchmark were sufficient to allow for member access and provider retention.
- However, planned additional research may reveal more information that could lead to a different conclusion.
- The ten ASC code grouping rate ratios ranged from 29.71% to 139.02%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Medicare reimburses more services in ASC settings than Colorado Medicaid.
- Medicare practices Multiple Procedure Discounting (MPD), Colorado Medicaid does not. Feedback indicates that, as a result, providers may choose between two options:
 - perform procedures at different times to be reimbursed for each procedure individually; or
 - perform multiple procedures to be reimbursed for only the most complex procedure.
- There is potential for cost savings if more procedures were reimbursed in ASC settings compared to those currently reimbursed in outpatient hospital settings.

DEPARTMENT FEEDBACK

- ASCs tend to be located in more populated areas. As such, members living in rural and frontier areas often drive more than an hour to receive care in an ASC setting.
- Care that could be provided in an ASC is sometimes provided in a hospital setting.
 - On behalf of participating states, the Medicaid Evidence-based Decisions Project (MED) is currently conducting an analysis of best practices for migrating appropriate care from the hospital to the ASC setting. The Department will evaluate findings once completed later in 2019.
 - At times, it is more appropriate for certain procedures to be conducted in the hospital setting. For example, when members present as medically complex.
- The Department is evaluating additional services for reimbursement in an ASC setting.²

¹ See pages 13-20 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.

² A working list of ~300 codes is currently being reviewed from a clinical and academic perspective to determine a final list of procedures to make available to Medicaid members in ASC settings. To develop this list: a crosswalk was completed of covered Medicare and Medicaid ASC services to identify codes that Medicare reimburses in ASC settings, but that Medicaid does not; next, Medicaid non-covered services were excluded; next, services determined to be unsafe in ASC settings were excluded, including spinal and vascular surgeries.



- For those codes currently open in an ASC setting, the Department is evaluating what share of all utilization is provided in hospitals compared to ASCs.

WORKING RECOMMENDATION(S)

- The Department recommends adding clinically appropriate procedure codes to the list of services that can be reimbursed in an ASC setting.
- The Department recommends eliminating the ASC grouper reimbursement methodology in favor of setting individual procedure rates.
- The Department recommends, once complete:
 - re-evaluating each service rate relative to the benchmark; and
 - evaluating individual services that are identified to be below 80% and above 100% of the benchmark to identify services that would benefit from an immediate rate change.³
- The Department recommends evaluating the potential for creating a Multiple Procedure Discounting reimbursement methodology.
- The Department recommends additional evaluation of whether costs can be offset by incentivizing migration of appropriate procedures from the hospital to the ASC setting.

FEE-FOR-SERVICE (FFS) BEHAVIORAL HEALTH SERVICES

ANALYSIS RESULTS⁴

- Analyses suggest that FFS behavioral health service payments at 94.67% of the benchmark were sufficient to allow for member access and provider retention.
- Individual FFS behavioral health service rate ratios ranged from 22.71% to 231.23%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Department did not receive stakeholder feedback for FFS behavioral health services.

DEPARTMENT FEEDBACK

- Regional Accountable Entities (RAEs) are the primary access point for behavioral health services. Each RAE negotiates provider reimbursement rates.

³ This recommendation will allow the Department to adjust rates so that the deviation from the benchmark, and the methodology used to set said rates, is reasonably consistent across services. The Department will conduct additional analysis to ensure rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

⁴ See pages 21-26 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.



- FFS behavioral health services are only billed when a member who needs that service has a diagnosis that is not covered by the RAEs.
- FFS behavioral health rates are generally lower than RAE rates.⁵
- Subsequent to the period of review, the Department took independent action to increase the rate for code 90792, Psychiatric Diagnostic Evaluation with Medical Services, to 100% of the national Medicare non-facility rate.

WORKING RECOMMENDATION(S)

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

RESIDENTIAL CHILD CARE FACILITIES (RCCFS)

ANALYSIS RESULTS⁶

- Analyses are inconclusive to determine if RCCF payments at 68.55% of the benchmark were sufficient to allow for member access and provider retention.
- RCCF individual rate ratios ranged from 47.00% to 100.64% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- RCCF rates are not sufficient to offer competitive staff wages or retain specialized providers.
- RCCFs and PRTFs cannot operate on the same campus.

DEPARTMENT FEEDBACK

- RCCF services are reimbursed in accordance with the behavioral health fee schedule; the Department does not pay differentially based on place of service.⁷
- Rates were last set in 2006; subsequent across-the-board (ATB) rate increases have resulted in minimal increases to total reimbursement rates.
- The level of staffing and type of clinicians needed to provide services to higher acuity members in the RCCF setting often exceeds what is required when those same services are provided to members outside an RCCF setting.

⁵ See [Appendix T](#) for a list of codes covered by the RAE behavioral health capitated program.

⁶ See pages 27-31 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.

⁷ RCCF providers are reimbursed a facility rate by the county. Counties place members into RCCFs and negotiate the facility rate with RCCF providers.



- Medication management in RCCF settings differs from medication management elsewhere. For example, there is a need for specialized psychiatric prescribers. However, there is only one rate for medication management regardless of setting.
- The totality of services provided in RCCFs should be considered when setting rates given they provide services for higher complexity cases and have expanded their scope of practice to care for children needing 24-hour medical services.
- The state has a strong focus on prevention of out-of-home placement; which may mitigate the number of needed RCCF placements. For example:
 - The Family Services Improvement and Innovation Act⁸ enabled states to operate a coordinated program of family preservation and community-based family support services designed to help families alleviate crises and maintain the safety of children in their own homes.
 - A Colorado Title IV-E Waiver Demonstration Project⁹ coordinated through the Colorado Department of Human Services and scheduled to sunset in September 2019¹⁰ enabled child welfare agencies to use block allocation funding to prevent foster care entry, increase permanency, prevent short stays in placement, and reduce/prevent placement reentry.
- The federal Family First Preservation Services Act¹¹ passed on February 9, 2019, creating the Qualified Residential Treatment Program (QRTP) starting October 1, 2019. QRTPs must meet federal requirements including 24-hour access to medical care.
 - It is unknown how the QRTP certification will affect access to care; however, the Department anticipates that most RCCFs will seek QRTP certification, which may impact access.

WORKING RECOMMENDATION(S)

- The Department recommends evaluating a way to differentiate payments for RCCFs from other FFS behavioral health services.
- The Department recommends a joint RCCF and PRTF rate setting project using Department best practices for incentivizing proper use of each facility type.^{12,13}

⁸ [P.L.112-34](#); reauthorized the Promoting Safe and Stable Families and Child Welfare Services program through FY 2016.

⁹ For more information, visit https://www.acf.hhs.gov/sites/default/files/cb/compiled_profiles.pdf, p.20-25

¹⁰ These funds will be replaced by funding through the federal Family First Preservation Services Act (see footnote below); it is unclear at this time whether certain demonstration activities and associated funding will continue.

¹¹ [H.R.253](#); aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skills training. It also seeks to improve the well-being of children already in foster care by incentivizing states to reduce placement of children in congregate care.

¹² Please see the [Establishing Provider Payment Rates and Methodologies Fact Sheet](#) for more information regarding the difference between the Department rate setting and rate review processes.

¹³ When conducting this project, the Department will also consider QRTP as a new facility type and statewide initiatives to keep children in the home and community, as appropriate.



- The Department recommends evaluating the regulatory requirements regarding co-location of RCCFs and PRTFs on the same campus to better understand factors impacting service delivery.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFS)

ANALYSIS RESULTS¹⁴

- Analyses were inconclusive to determine if PRTF payments at 114.36% of the benchmark were sufficient to allow for member access and provider retention.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The PRTF per diem rate is not sufficient to cover operational costs.

DEPARTMENT FEEDBACK

- PRTFs treat high acuity individuals who need 24-hour medical services.
- There are five facilities that are licensed as both PRTFs and RCCFs in the state of Colorado; however, only one of those campuses provides services for Medicaid members due to a variety of regulatory requirements and market factors.
- The Department is conducting further analysis to quantify the extent to which reimbursement of services in RCCF settings differs from the PRTF per diem rate.
- Additional research is needed to fully understand why utilization of PRTFs is low. The Department is performing ongoing PRTF analyses in alignment with the implementation of federal regulations.
- The state has a strong focus on prevention of out-of-home placement, which may mitigate the number of PRTF placements. *See RCCF Key Considerations section above for examples.*
- The federal Family First Preservation Services Act¹¹ passed on February 9, 2019, creating the Qualified Residential Treatment Program (QRTP) starting October 1, 2019. QRTPs must meet federal requirements including 24-hour access to medical care.
 - It is unknown how the QRTP certification will affect access to care; however, the Department anticipates that most RCCFs will seek QRTP certification, which may impact access.

WORKING RECOMMENDATION(S)

- The Department recommends a joint RCCF and PRTF rate setting project using Department best practices for incentivizing appropriate placement in each facility type.^{12,13}

¹⁴ See pages 32-33 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.



SPECIAL CONNECTIONS PROGRAM SERVICES

ANALYSIS RESULTS¹⁵

- Analyses were inconclusive to determine if Special Connections payments between 9.78% and 630.72% of the benchmark were sufficient to allow for member access to provider retention.
- The per diem rate of \$192.10 specific to the Special Connections Program is at 114.54% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- Although the per diem rate of \$192.10 is at 114.54% of the benchmark, it is still too low to cover daily facility costs.
- There are only 56 beds available statewide for various programs across multiple payors; these are not limited to Special Connections Program participants.
 - Providers consider medical complexity and associated need of child care and whether additional beds will be taken up by dependent children when determining enrollment of Special Connections participants compared to non-Special Connections participants.

DEPARTMENT FEEDBACK

- The Office of Behavioral Health (OBH) is increasing room and board rates from \$90 to \$210 per diem starting July 1, 2019.¹⁶
 - There is no additional room and board rate for dependent children accompanying mothers in the program; however, the Family First Prevention Services Act could provide this for members who have child welfare involvement at \$54 per diem for the child's costs.
- Increases to the total reimbursement for Special Connections may provide participants with improved placement options.
- Claims re-billing is planned in the next two months; this claims data is needed to project cost of rate changes and further inform access analysis.
- OBH does not have a mandatory, formal process for documenting the following Special Connections program information:
 - success and attrition rates;
 - waitlist data for members seeking care; and

¹⁵ See pages 34-37 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.

¹⁶ While this will affect reimbursement, the increase to room and board reimbursement will not change the data or conclusions from the rate comparison analysis since this payment was not included in the Department's analysis.



- a consistent definition for what is considered successful completion.¹⁷
- OBH is working to improve data collection efforts, including the implementation of the [COMPASS project](#). The Department will follow-up with OBH periodically to ensure data is shared as available, as this information is necessary to further inform Department Special Connections initiatives.
- Other legislation that will impact access for pregnant and parenting mothers:
 - [HB19-1193](#) will expand the eligibility period for Special Connections to include post-natal members.
 - [SB19-228](#) will further integrate SUD treatment and OB/GYN services (e.g., employing OB/GYN providers in SUD treatment centers and SUD treatment professionals in OB/GYN settings).

WORKING RECOMMENDATION(S)

- The Department recommends further evaluating whether initiating a rate setting project would be beneficial.
- The Department recommends conducting a provider survey to augment the lack of data currently available and to identify areas for impacting program improvement.
- The Department recommends further aligning with and supporting OBH efforts to increase data availability, consistency, and validity.

DIALYSIS AND END-STAGE RENAL DISEASE (ESRD) SERVICES

ANALYSIS RESULTS¹⁸

- Analyses suggest that dialysis and ESRD service payments at 83.22% of the benchmark were sufficient to allow for member access and provider retention.
- Dialysis and ESRD regional facility rate ratios ranged from 73.46% to 90.02%.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- The Department did not receive stakeholder feedback specific to dialysis and ESRD services.

DEPARTMENT FEEDBACK

- Most Medicaid members with ESRD become eligible for Medicare ~90 days after beginning facility-based dialysis treatment.¹⁹

¹⁷For instance, OBH has indicated that there is a provider practice that views successful completion as completion of certain curriculum that results in the member being discharged to a lower level of care or back into the community.

¹⁸ See pages 38-44 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.

¹⁹ ESRD patients are eligible for Medicare the first day of the fourth month of facility-based treatment.



- Medicaid members with ESRD who receive an in-home dialysis training become eligible for Medicare on the day of that training or the first day of in-home treatment, whichever is first (e.g. they don't have to wait ~90 days).
 - Code 98089, Dialysis Training, is currently being billed so infrequently that the Department had to block the number of claims in the report for PHI reasons.²⁰
- In-home dialysis is preferable care for certain members. Several clinical and academic studies have highlighted the health, social, and economic benefits of in-home dialysis.
- Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) are two types of in-home dialysis. Medicare accounts for each day (seven per week) a patient receives CAPD or CCPD and then applies a unit conversion calculation to arrive at the number of days (three) per week that patient would have visited a clinic, were they receiving hemodialysis in a facility setting. Medicare then reimburses providers an equivalent rate. Medicaid does not currently apply a similar unit conversion calculation; it appears that Medicaid reimburses the same rate for each *day* a patient receives CAPD or CCPD as it does for each *visit* to a dialysis facility (e.g. Medicaid pays more for in-home dialysis).

WORKING RECOMMENDATION(S)

- The Department recommends evaluating factors that impact utilization of in-home dialysis, including Medicare enrollment, and how to improve access to in-home dialysis options where appropriate.
- The Department recommends evaluating the potential to implement changes to reimbursement for in-home Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis services, to align more closely with the Medicare payment methodology.

DURABLE MEDICAL EQUIPMENT (DME)

ANALYSIS RESULTS²¹

- Analyses suggest that DME payments at 100.75% of the benchmark for rates not subject to federal Upper Payment Limit (UPL) were sufficient to allow for member access and provider retention.²²
- Current data suggest that DME rates subject to UPL are sufficient for member access and provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

²⁰ The Department is evaluating at which point these patients become eligible for Medicare; Medicare may be paying initial training costs once it becomes the primary payer.

²¹ See pages 45-52 of the [2019 Medicaid Provider Rate Review Analysis Report](#) for more information.

²² [The Consolidated Appropriations Act of 2016](#) requires Colorado Medicaid to reimburse certain DME codes at no greater than 100% of the Medicare rate if those codes were covered by both Medicare and Medicaid in the previous fiscal year. DME codes subject to the limit do not include orthotics, prosthetics, and disposable supply codes. States can set rates above the UPL (e.g., above 100% of the Medicare rate) but must use state-only funds; this limits the State's ability to increase rates. For a list of DME UPL codes, see the [DME UPL fee schedule](#) on the Department website.



- Individual DME service rate ratios for non-UPL DME ranged from 3.9% to 1,478% of the benchmark.

KEY CONSIDERATIONS

STAKEHOLDER FEEDBACK

- UPL legislation has created an access barrier to some services that received rate reductions.

DEPARTMENT FEEDBACK

- Data did not indicate access was impacted by UPL implementation. However, the Department does not yet have the 18 months of claims run-out data necessary to observe the full impact of the change since UPL rates were implemented in January 2018 and the State provided additional reimbursement to certain DME providers through April 2018.²³
 - The Department will continue to analyze claims data up through 22 months post UPL implementation, to determine if provider retention and service utilization patterns changed and to quantify any change.
- Potential recommendations for UPL DME may require a non-fiscal approach given rates cannot be raised above the UPL.
- For those DME rates not subject to the UPL, analysis showed certain rates were significantly below 80% and above 100% of the benchmark.

WORKING RECOMMENDATION(S)

- The Department will continue to evaluate and monitor access to care for services subject to federal Upper Payment Limits and work with state and federal partners to identify solutions to impacted services.
- The Department recommends rebalancing the DME rates not subject to Upper Payment Limits and will evaluate individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark to identify services that would benefit from an immediate rate change.³

²³ The original effective date was January 2019; however, the [21st Century Cures Act](#) changed the effective date to January 2018. In CY 2018, 244 DME codes were subject to this UPL, 137 of which are included in the Year Four rate review.