Health Care Policy & Financing SB15-228: Rate Review Schedule

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Slides from HCPF – Comments and Views Solely Those of Dr. Pace

COLORADO
Department of Health Care Policy & Financing

Background

- The Department oversees and operates Colorado Medicaid, Child Health Plan *Plus* (CHP+), and other public health care programs for the state of Colorado
- CRS 25.5-4-401.5 requires the Department to create a Rate Review Process and schedule to ensure an analysis of each Medicaid provider rates at least every five years, and include:
  - An analysis of access, service, quality, and utilization of each service subject to review
  - A comparison of Medicaid rates against Medicare, usual and customary rates paid by private pay parties, and other benchmarks
- **Designed to ensure payments are sufficient to allow for provider retention, client access, and to support appropriate reimbursement of high value services**

Background

- The Rate Review Process will be completed in four phases:
  1. Develop a five-year schedule of rates to review
  2. Conduct analyses of and rate comparisons for rates under review that year
  3. Develop strategies for responding to the analyses results
  4. Provide annual recommendations on all rates reviewed
- A *review* of rates does not mean a change to rates
- Any proposed rate changes are subject to the Department's regular budget process
- Out of cycle changes could impact the proposed schedule

Focus of Committee
My Perspective

- *Large committee with varied constituents*
- *Some groups have more organized lobbying concerning rates than others*
- *All members allowed to participate in all decisions (no exclusions for COI)*
- *Rates recommendations should include actual costs, impact on access and impact on quality*
- *Impact of rate or delivery decisions on total costs appear to be of interest to the committee*
- *Review/decisions by full group*
- *Final rates set by legislative process*

Rate Setting and the Rate Review Process

Rate Setting and Rate Reviews

- Although they are related, it is important to distinguish the difference between the Department's ongoing rate setting work and the new Rate Review Process
- The Department's <u>rate setting</u> work focuses on a narrow and specific set of rates or services. Some examples of ongoing rate setting and rate maintenance include:
  - Update and maintenance of provider and health plan rates
  - The addition, re-designation, or deletion of procedure codes for an existing set of services
  - Rates that need to be adjusted as a result of budgetary appropriations
- In contrast, the <u>Rate Review Process</u> will provide a full analysis of access and utilization for a broader set of rates and services

Five Year Rate Review Schedule

Five Year Schedule

Year One (December 2015 – May 2016)

Service Type	No. of Codes	No. of Rates
County and Brokered Non-Emergent Transportation	17	17
Emergency Transportation	12	12
Private Duty Nursing	5	5
Home Health	22	10
Pathology and Laboratory	1,515	1,515
Physician Administered Drugs (J Codes)	743	743
Total	**2,314**	**2,302**

The focus for Year 1 is on service types in programs that are clearly defined, where policies for the codes have been static, where rates and their methodologies are known, and procedure codes are easily comparable to other benchmarks

Proposed Rates to be Excluded from the Rate Review Process

Proposed Exclusions

The Department is recommending a number of service categories be excluded from the Rate Review Process:

- Rates based on costs
- Rates that already have a regular process for updates that is delineated in statute or regulation
- Rates under a managed care plan
- Payments unrelated to a specific service rate

Proposed Exclusions

Medicaid payer of last resort: Crossover claims do not reflect a payment for specific services.

Incentive Payments: These rates are contractually-based and calculated based on providers meeting a set of quality indicators specific to the contracted group

Contracted Plans: Contracted Health Maintenance Organizations (HMO) and Behavioral Health Organizations (BHO) reimbursements are based on an annually-calculated per-member per-month or capitated rate.

Proposed Exclusions

Selected Regular Rate Setting Work:

Inpatient Hospitals: Rates are revised annually and based on updated Medicare base rates with specific Medicaid cost-add-ons. The payment methodology uses Diagnosis Related Groups (DRG) weights that are updated at least every other year.

DRG Grouper: This is a service category that refers to the weights used for inpatient hospital services

Outpatient Hospital: Except for Transportation, payment for outpatient hospital services is based on costs (transportation will not be affected by the EAPG transition and will be reviewed in Year 1)

Proposed Exclusions

Clinic:
FQHC and **RHC:** Federally Qualified Health Centers and Health Centers are Rural reimbursed prospectively

School Based Clinic Services and **School Based Clinic Case Management:** These services are reimbursed at cost. Rates are based on a per unit reimbursement, reconciled annually through a cost settlement

Prescribed Drugs:
Title XIX Drugs: Rates are under continual review: compliance with federal regulations requires ongoing rate revision due to the continuous fluctuation of prices

Proposed Exclusions

Facility:
Nursing Facility Class I and **Class V:** Nursing facility rates are cost-based and calculated annually following the submission of cost reports

Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID) Class II and **Class IV:** ICF rates are cost based and calculated annually following the submission of cost reports. ICF/IID reimbursement requires annual rate updates

Questions?