DEPARTMENT OF HEALTH CARE POLICY AND FINANCING QUESTIONS ON THE PROVIDER RATE REVIEW SCHEDULE

1. [Sen. Moreno] Does the Department have any concerns with the JBC's directive to add nursing home rates to the review schedule for year 5 (with a recommendation report due November 2020)?

   Yes, the Department has concerns with nursing home rates being added to the Year Five rate review. Per section 25.5-4-401.5(1)(c)(I), C.R.S., the Department excluded rates from the rate review schedule because those rates are adjusted on a periodic basis as a result of other state statute or federal law or regulation, and took into account those exclusions on the approved rate review schedule. Service categories were generally excluded when those rates: are based on costs; have a regular process for updates, and that process is delineated in statute or regulation; are under a managed care plan; or are payments unrelated to a specific service rate. Nursing Facility rates were excluded because Nursing Facility reimbursement is governed by section 25.5-6-202, C.R.S., which requires that rates are updated annually and based on costs reported by facilities each July 1. Further, the MPRRAC composition does not include a representative of nursing facilities; the committee would lack necessary representation to inform nursing facilities discussions.

   The Rate Review Process is a comprehensive, lengthy, and time and labor-intensive process. The Department began work on Year Five services earlier this year, with actuarial work beginning in the summer, and the MPRRAC meetings beginning 11/15/19. In FY 2020-21 R-8, "Accountability and Compliance Improvement Resources," [1] the Department requested 1.0 additional FTE and contractor funds to conduct additional research and evaluation to provide more robust analysis for the existing schedule. Given the Nursing Facility scope of work, the Department would not have adequate time to complete data and actuarial analyses, and MPRRAC and stakeholder engagement, for inclusion in the 2020 Medicaid Provider Rate Review Analysis Report.

   Current Skilled Nursing Facility rate setting is conducted on a prospective, annual basis and is comprised of a number of components related to audited costs that are then subjected to a complex rate methodology. The components include; Room and Board, nutrition, limits on growth, real estate valuation, incentives for reducing overhead, quality-based metric incentives, individualized resident acuity, and add-ons for behavioral health programs. The statute already requires annual audits of actual costs which result in rates that are responsive to changing market conditions. In practice, this process results in annual 3 percent rate increases for nursing facilities.

[1] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-8%20Accountability%20and%20Compliance%20Improvement%20Resources.pdf

The Department has proposed funds for a rate reimbursement review as part of its FY 20-2021 budget request (R-17, "Program Capacity for Older Adults").[2] This is intended to include a review of existing rate reimbursement components, potential improvements to the existing structure, as well as a comparison to other state reimbursement systems. The Department requested funding to facilitate stakeholder meetings to review the options from the analysis with relevant stakeholders. The Department would use the results of the contractor study and stakeholder feedback to propose a new reimbursement methodology that takes into consideration the case-mix of nursing facility residents, the acuity level of residents, and anticipated resources needed for a patient. The goal is to create a payment methodology that would require nursing facilities to carefully manage how they deliver services in order to provide the most appropriate level of care for each resident.

2. [Sen. Moreno] If a local government implements a local minimum wage, pursuant to H.B.19-1210, are there provider rates that should be adjusted (beyond the adjustment to nursing home rates required by the bill)? What is the Department doing to plan for this potential contingency and how quickly after receiving an appropriation could a rate adjustment be implemented?

An increase in the Denver minimum wage could lead HCPF to re-assess provider rates for personal care services, homemaking services, health maintenance activities, and residential habilitation services.

It is critical to note that while the minimum wage bill in question is specific to the City and County of Denver, it will have far reaching impacts. In our research around direct care worker compensation, increasing the wage in one county of a densely populated area creates significant issues for the entirety of a metropolitan area. Direct care worker migration from providers in non-increased municipalities coupled with providers leaving that very same area, may create significant access to care issues. Further, the Department also shares concern about the impact of rural providers, as they already report struggling with workforce migration issues.

Rate adjustments for State Plan services generally require approval by the Centers for Medicare and Medicaid Services (CMS). This process requires the Department write amendments, post 30-day public notices, and then 90 days for CMS review. CMS' review can take more or less than 90 days depending on CMS' requests for additional information. The new rates can be implemented within a week of receiving CMS approval or by the effective date, whichever comes later.

Rate adjustments for Waiver services also generally require approval by the Centers for Medicare and Medicaid Services (CMS). The ability to quickly implement a waiver rate adjustment depends on the percent change. For instance, any increase that would be

---

[2] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-17%20Program%20Capacity%20for%20Older%20Adults.pdf

above 10 percent of the approved waiver projections requires an amendment to the applicable waiver(s). This process requires the Department develop the amendments, post for 30-day public comment, and then allow for 90 days of CMS review. CMS' review can take more or less than depending on other complexities in the waiver amendment(s) and CMS' requests for additional information.

3. [Sen. Rankin] Please discuss what the Department and MPRRAC do to look at the regional adequacy of rates. Are there rates where Medicaid should make a regional adjustment? What barriers exist to paying on a regional basis?

   The Department conducts access to care analyses specific to Urban, Rural, and Frontier regions, which include distinct utilizers over time, active providers over time, panel size, member-to-provider ratios, and drive times. These data points measure realized access (penetration rate), potential access (member-to-provider ratio), and provider availability (panel size and active months) over the three regional classifications. In addition, the Department reviews and publishes maps showing utilizer density (utilizer counts) and penetration rates (estimated percentage of total Medicaid users who received the service) by county. The maps provide context at the county-level to help indicate the source of potential issues, allowing the Department to focus follow-up efforts to specific regions. The Department considers regional data into account when forming conclusions and recommendations.

   When appropriate, the Department takes regional rates into account in the contracted actuarial analysis, such as with Durable Medical Equipment. The Department also uses a regional payment system based on Wage Index Regions for the reimbursement of dialysis services, similar to how Medicare pays based on a wage index. The dialysis facility rate for each Wage Index Region was compared to the benchmark (Medicare). The Department has proposed new case management rates for Single Entry Points (SEPs) and Community Centered Boards (CCBs) that will be effective July 1, 2020, that for the first time include geographic modifiers.

   There are barriers to paying rates at a regional level. Implementing a geographic-based rate methodology would require approval from the Centers for Medicare and Medicaid Services (CMS). Geographic-based rate methodologies would require changes to the Department's claims system and the coding that providers use to bill for delivered services. In addition, in some cases, there is a lack of comparison information for the MPPRAC to evaluate; for example, for durable medical equipment, Medicare rural and non-rural rates, as well as the competitive bidding area rates do not have a one-to-one comparison to Colorado Medicaid.

4. [Sen. Zenzinger] Home health rates are scheduled for review in year 5 (with a recommendation report due November 2020) and personal care rates are scheduled for review in year 1 (with a recommendation report due November 2021). Given the overlap

in providers and recipients of these services, could/should we align the reviews to occur in the same year?

The Department does not recommend reviewing HCBS personal care services separately from other waiver services. There is significant overlap in providers and recipients of HCBS waiver services. While a few Home Health providers are also certified to provide HCBS personal care services, the scope of practice, authorization of services, and service delivery methods are inherently different. It is important that individual HCBS waiver services be evaluated concurrently with the other services within each waiver to promote consistent implementation and delivery of services to recipients. Additionally, timelines at this stage would be extremely condensed to complete data and actuarial analyses, which would impact the Department's ability to engage the MPRRAC and stakeholders in meaningful ways prior to the development of the Medicaid Provider Rate Review Analysis Report and in time for the February 2020 MPRRAC meeting.

State Plan Home Health and Pediatric Personal Care services are scheduled for review in Year Five. The Department began work on Year Five services earlier this year, with actuarial work beginning in the summer, and the MPRRAC meetings beginning 11/15/19. The Department will start work on Year One services, including HCBS waiver services, in the spring of 2020. Review will include HCBS personal care services, which are available through several HCBS waivers.

MPRRAC meetings regarding the overall schedule were held on 6/14/19 and 6/28/19. The Department, informed by MPRRAC and past stakeholder feedback, was intentional to review services in the same year with the most alignment across members and providers and the continuum of care. Fee-for-service Speech Therapy, Physical and Occupational Therapy, Pediatric Behavioral Therapy, Pediatric Personal Care, Home Health, and Private Duty Nursing services were scheduled in the same year of review for these reasons. It was necessary to schedule HCBS waivers services within its own year of review with minimal, but other highly related services, such as Targeted Case Management, given the amount and scope of work required to review HCBS Waiver services. The Department scheduled these State Plan and Waiver services in adjacent years of review to assess the full continuum of care, data, and stakeholder and MPRRAC feedback, and create alignment across and within years of review. This allows the services with the greatest alignment to be reviewed within the same year, while creating streamlined evaluation and improved opportunity for MPRRAC and stakeholder feedback across years. The MPRRAC was provided a final opportunity to change the five-year rate review schedule when they met on 11/15/19, and chose to have it remain as is, and did not explore stakeholder feedback provided in the same meeting to move personal care services to this year of review (Year Five).

5. [Sen. Moreno] Please provide a list of recommended actions by the MPRRAC or the Department that have not been fully implemented. For example, in the 2016 report the

MPRRAC recommended that the Department increase home health rates to 90 percent of Medicare's Low-Utilization Payment Adjustment (LUPA) over three years.

The Department's Medicaid Provider Rate Review Recommendation Report is informed by rates, access, and quality data and actuarial analysis results, Department subject matter experts, and MPRRAC and stakeholder feedback.

- All Year One (2016) recommendations were completed or implemented. Year Two (2017) Department recommendations that were approved and received funding were implemented.
- The Department is concluding implementation of Year Three (2018) recommendations that were approved for implementation in FY 2019-20, which include rebalancing evaluation and management, primary care, radiology, physical and occupational therapy, and physician services and surgeries rates, as well as increasing maternity rates.
- The Department is working on a payment methodology for physician services and surgeries that differentiates rates based on place of service.
- The Department requested funding to implement Year 4 recommendations as part of the FY 2020-21 R-10, "Provider Rate Adjustments,"[3] submitted on November 1, 2019.

More information can be found in the status update that was shared at the most recent MPRRAC meeting on 11/15/19.

Per the Long Bill narrative[4], the Department was appropriated funding in FY 2017-18 to increase home health rates by one-third of the difference between current rates and 90 percent of Medicare's LUPA rates. The Department did not receive funding for additional increases beyond FY 2017-18 for home health rates.

[3] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY21%2C%20R-10%20Provider%20Rate%20Adjustments.pdf

[4] leg.colorado.gov/sites/default/files/17lbnarrative.pdf, page 44-45