COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 1, 2022

The Honorable Julie McCluskie, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative McCluskie:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Joint Budget Committee on the Medicaid Provider Rate Review Recommendation Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Physician Services, Dialysis and Nephrology Services, Laboratory and Pathology Services, Eyeglasses and Vision Services, Injection and Miscellaneous J-Codes, and two out-of-cycle reviews (Physical, Occupational, and Speech Therapy and Outpatient Hospital Specialty Drugs) under review in year two (cycle two) of the Rate Review Process.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer

Executive Director

KB/EH

CC: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
Cristen Bates, Interim Medicaid Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Office Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 1, 2022

Dixie Melton, Chair
Medicaid Provider Rate Review Advisory Committee
303 East 17th Avenue
Denver, CO 80203

Dear Ms. Melton:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Medicaid Provider Rate Review Advisory Committee on the Medicaid Provider Rate Review Recommendation Report.

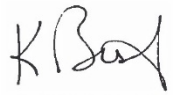
Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to submit a written report to the Joint Budget Committee and the advisory committee containing its recommendations on all of the provider rates pursuant to this section and all of the data relied upon by the state department in making its recommendations by November 1. The Joint Budget Committee shall consider the recommendations in formulating the budget for the state department.

The Department's report contains recommendations for: Physician Services, Dialysis and Nephrology Services, Laboratory and Pathology Services, Eyeglasses and Vision Services, Injection and Miscellaneous J-Codes, and two out-of-cycle reviews (Physical, Occupational, and Speech Therapy and Outpatient Hospital Specialty Drugs) under review in year two (cycle two) of the Rate Review Process.

If you require further information or have additional questions, please contact the Department's Fee-for-Service Rates Division Director Kevin Martin as kevin.martin@state.co.us or 303-866-3201.

Sincerely,

Kim Bimestefer



Executive Director

KB/EH

CC: Vennita Jenkins, Vice Chair, Medicaid Provider Rate Review Advisory Committee
Melissa Benjamin, Medicaid Provider Rate Review Advisory Committee
Tim Dienst, Medicaid Provider Rate Review Advisory Committee
Dave Friedenson, Medicaid Provider Rate Review Advisory Committee
Rob Hernandez, Medicaid Provider Rate Review Advisory Committee
Kim Kretsch, Medicaid Provider Rate Review Advisory Committee
David Lamb, Medicaid Provider Rate Review Advisory Committee
Bryana Marsiano, Medicaid Provider Rate Review Advisory Committee
Gretchen McGinnis, Medicaid Provider Rate Review Advisory Committee
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Jo Donlin, Legislative Liaison, HCPF

Medicaid Provider Rate Review Recommendation Report

Nov. 1, 2022

Submitted to: The Joint Budget Committee and the Medicaid Provider Rate Review Advisory Committee

COLORADO
Department of Health Care Policy & Financing

Contents

COLORADO
Department of Health Care Policy & Financing

Executive Summary

Section 25.5-5-401.5(2)(d), C.R.S. requires the Department of Health Care Policy & Financing (the Department) to "…submit a written report to the joint budget committee and the [Medicaid Provider Rate Review Advisory] committee containing its recommendations on all of the provider rates reviewed…" as part of the annual rate review cycle established pursuant to section 25.5-5-401.5(1), C.R.S. This report contains the Department's recommendations for the 2022 rate review cycle.

For this report, the Department has reviewed the following services:

- Physician services, including: cardiology; cognitive capabilities assessment; ear, nose, and throat (ENT); gastroenterology; health education; ophthalmology; primary care/evaluation and management (E&M); radiology; respiratory; vaccines and immunization; vascular; women's health and family planning; and other physician services
- Dialysis and nephrology services
- Laboratory and pathology services
- Eyeglasses and vision services
- Injections and miscellaneous J-codes
- Physical, occupational, and speech therapy
- Outpatient hospital specialty drugs

As part of the review, the Department evaluated each service and performed the following: 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. The Department's analysis was published in May 2022 and is available on our website.

In general, for all services reviewed, the Department recommends increasing rates for services that are below 80% of benchmark rates to 80% of the benchmark rate and decreasing rates for services that are above 100% of the benchmark rate to 100% of the benchmark rate. In a small number of cases denoted in the report, the Department recommends maintaining some rates above 100% of the benchmark rate to ensure appropriate access to services.

The Department's recommendations were informed by the 2022 Medicaid Provider Rate Review Analysis Report, as well as feedback from the Medicaid Provider Rate Review Advisory Committee and stakeholders. The recommendations were developed after working with the Office of State Planning and Budgeting (OSPB) to determine priorities and achievable goals within the statewide budget.

The Department estimates that implementing the recommendations outlined in this report would cost $41.4 million total funds, $12.4 million General Fund in FY 2023-24. The Department has requested funding for these recommendations through its Nov. 1, 2022, budget request R-7 "Provider Rate Adjustments."

I. Introduction

The Colorado Department of Health Care Policy & Financing (the Department) administers the state's public health insurance programs, including Health First Colorado (Colorado's Medicaid Program), 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. The Department's mission is to improve health care equity, access, and outcomes for the people it serves while saving Coloradans money on health care and driving value for Colorado.

In 2015, the Colorado State Legislature adopted SB 15-228 "Medicaid Provider Rate Review," an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with section 25.5-4-401.5, C.R.S., the Department established an evidence-based Rate Review Process that involves four components:

1. Assess and, if needed, review a five-year schedule of rates;
2. Conduct analyses of service, utilization, access, quality, and rate comparisons for services under review and present the findings in a report published the first of every May;
3. Develop strategies for responding to the analysis results; and
4. Provide recommendations on all rates reviewed and present them in a report published the first of every November.

SB 22-236, which directly impacts the Department's Rate Review Process, was recently signed into law. As a result of this bill, this will be the last recommendation report based on the five-year rate review cycle established pursuant to section 25.5-5-401.5(1). The 2023 Medicaid Provider Rate Review Recommendation Report will follow SB 22-236 guidelines, including shifting the five-year rate review cycle to a three-year rate review cycle. The Department must establish the new schedule for reviewing rates by Sept. 1, 2023. In addition, beginning in July 2023, the Department will no longer provide a separate rate analysis report; the analysis report and the recommendation report will be combined into a single report due November 2023. Further, SB 22-236 made revisions to the membership of the MPRRAC itself, effective Dec. 1, 2022.

The Rate Review Process is informed by the MPRRAC and stakeholders, who participate via public quarterly meetings and written communication. The MPRRAC and stakeholders provide feedback to the Department on its analyses and recommendations, which are later published in reports by the Department.

MPRRAC meetings for Year Two (Cycle Two) services of the five-year rate review cycle began in November 2021 and concluded in September 2022. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are on the Department website.

On May 2, 2022, the Department published the 2022 Medicaid Provider Rate Review Analysis Report.

Report Purpose

This document serves as the second report in the annual Rate Review Process. It briefly summarizes what was learned through the Rate Review Process, the Department's recommendations for services reviewed in Year Two (Cycle Two), and considerations taken in developing recommendations.

The Department's recommendations were informed by the 2022 Medicaid Provider Rate Review Analysis Report, as well as MPRRAC and stakeholder feedback. They were developed after working with the Office of State Planning and Budgeting (OSPB) to determine priorities and achievable goals within the statewide budget.

This report is intended to be used by the Joint Budget Committee (JBC) for consideration in formulating the budget for the state Department.

For this report, the Department has reviewed the following services:

- Physician services, including: cardiology; cognitive capabilities assessment; ear, nose, and throat (ENT); gastroenterology; health education; ophthalmology; primary care/evaluation and management (E&M); radiology; respiratory; vaccines and immunization; vascular; women's health and family planning; and other physician services
- Dialysis and nephrology services
- Laboratory and pathology services
- Eyeglasses and vision services

- Injections and miscellaneous J-codes
- Physical, occupational, and speech therapy
- Outpatient hospital specialty drugs

Reviews for physical, occupational, and speech therapy services were an "out-of-cycle" review, meaning that they were not originally part of the established rate review cycle. The Joint Budget Committee (JBC) requested that the Department compare outpatient physical therapy/occupational therapy (PT/OT) and speech therapy (ST) to home health PT/OT and ST. The Department was able to determine the amount paid per provider per day for PT/OT and ST and compared this to the per diem rate paid for home health PT/OT and ST. The committee also requested a review of outpatient hospital specialty drugs.

Payment Philosophy

The Department believes that a reasonable threshold for payments is 80%-100% of Medicare which is why Medicare rates are used as the primary benchmark. However, there are four primary situations where Medicare may not be an appropriate model when comparing a rate:

1. If Medicare does not cover services covered by Colorado Medicaid or if Medicare does not have a publicly available rate (e.g., Home and Community-Based Services (HCBS) waivers).
2. If Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g., pediatric services).
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., targeted case management (TCM)).
4. If there is a known issue with Medicare's rates.

When Medicare is not an appropriate comparator, the Department uses rates from other states with similar services to develop an appropriate benchmark comparison. In addition, the Department uses the access to care analysis report to determine if there is evidence of access issues that may lead to a rate being considered inadequate. Further, the Department uses its rate setting methodologies to develop rates. This methodology incorporates indirect and direct care requirements, facility expense

expectations, administrative expense expectations, and capital overhead expense expectations. While the Department views payments between 80%-100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below must also 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 developing feasible mitigation strategies;
- When access to care is identified as a concern even when rates are between 80% to 100% of Medicare;
- Identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and
- Developing systems to ensure that payments are associated with high-quality provision of services.

When the Rate Review Process indicates a current rate does not align with the Department's payment philosophy, the Department may recommend or implement a rate change. It is also important to note that the Department may not recommend a change, due to the considerations listed above.

Department Recommendations

The Department's recommendations generally take the form of "rebalancing" rates. For the purpose of this report, rebalancing means increasing rates lower than 80% to 80% of the benchmark rate and decreasing rates above 100% of the benchmark to 100% of the benchmark rate. The Department estimates that implementing the recommendations outlined in this report would cost $41.4 million total funds, $12.4 million General Fund in FY 2023-24. The Department has requested funding for these recommendations through its Nov. 1, 2022, budget request R-7 "Provider Rate Adjustments."

If approved through the budget process, the Department's recommendations would allow the Department to adjust rates so that rates are reasonable and consistent across services. If necessary, the Department will conduct further analysis to ensure

rebalancing would not disproportionately, and adversely, impact individual providers in a manner that would affect member access and provider retention.

Format of Report

Each section is formatted in the same way, and each section contains the following subsections:

Summary of Findings

This section provides a summary of the Department's findings through the Rate Review Process, which includes rate comparison and access analyses.

Key Considerations

This section provides a summary of the information and data that informed the development of the Department's recommendations, including MPRRAC and stakeholder feedback. The Rate Review Process is evidence-based; all MPRRAC and stakeholder feedback provided is valuable and informs the Department's work. The Department is committed to thoroughly and thoughtfully evaluating available evidence and MPRRAC and stakeholder feedback to make evidence-based decisions and recommendations.

Department Recommendations

This section lists the Department's recommendations for Year Two (Cycle Two) services as a result of the Rate Review Process. The Department recognizes that while the process of data analysis and standardized reporting is optimal for identifying outliers, this type of high-level analysis often leads to insights that require further in-depth research to investigate the reasons behind the data outliers and which mechanism is appropriate for intervention (e.g., rates, policy, etc.). Additionally, stakeholder feedback 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.

References

Throughout this report, there are references to prior Department work as part of the rate review process. All Department rate review work is available at

https://hcpf.colorado.gov/rate-review. This website contains the analysis report required by section 25.5-5-401.5(2)(a) for the current year and includes the analysis and recommendation reports for prior years.

II. Recommendations and Considerations

Physician Services

Cardiology

Summary of Findings

The Department found the payment rate for cardiology services was 90.7% of the benchmark; Colorado payments varied between 35.0%-358.1% of Medicare and an average of two other states' Medicaid rates. Of the 181 procedure codes analyzed in this service grouping, 177 were compared to Medicare, and four were compared to an average of two other states' Medicaid rates. States used in the cardiology rate comparison analysis were Nevada and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding cardiology services in the 2022 reporting cycle.

Other considerations include:

- Since cardiology services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, there was an increase in total active Cardiology providers; in addition, total expenditures increased by approximately $10 million, or 147.3%, since cardiology services were last reviewed, compared to a 4% increase in utilization.

Recommendations

The Department recommends:

1. Rebalancing cardiology rates for individual services that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Cognitive Capabilities Assessment

Summary of Findings

The Department found the payment rate for cognitive capabilities assessment services was 127.2% of the benchmark; Colorado payments varied between 69.0%-378.7% of Medicare and an average of six other states' Medicaid rates. Of the 12 procedure codes analyzed in this service grouping, 11 were compared to Medicare, and one was compared to an average of two other states' Medicaid rates. States used in the cognitive capabilities assessment rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding cognitive capabilities assessment services in the 2022 reporting cycle.

Other considerations include:

- Since cognitive capabilities assessment services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, total members accessing cognitive capabilities assessment services and total active cognitive capabilities assessment providers increased. In addition, total expenditures increased by nearly $5 million, an increase of 142.5%, compared to a 35.0% increase in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing cognitive capabilities assessment rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Ear, Nose, and Throat (ENT)

Summary of Findings

The Department found the payment rate for ear, nose, and throat (ENT) services was 76.4% of the benchmark; Colorado payments varied between 5.4%-835.4% of Medicare and an average of three other states' Medicaid rates. Of the 51 procedure codes

analyzed in this service grouping, 46 were compared to Medicare, and five were compared to an average of three other states' Medicaid rates. States used in the ENT rate comparison analysis were Arizona, Oklahoma, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding ENT services in the 2022 reporting cycle.

Other considerations include:

- Since ENT services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report both total members accessing ENT services and total active ENT providers increased. In addition, total expenditures increased by over $375,000, or 39.5%, compared to a 12.14% increase in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing ENT rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Gastroenterology

Summary of Findings

The Department found the payment rate for gastroenterology services was 63.5% of the benchmark; Colorado payments varied between 20.6%-107.9% of Medicare. All 19 procedure codes analyzed in this service grouping were compared to Medicare.

Key Considerations

The Department did not receive any feedback from stakeholders regarding gastroenterology services in the 2022 reporting cycle.

Other considerations include:

- Since gastroenterology services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, both total members accessing gastroenterology services and total active gastroenterology providers increased. In addition,

total expenditures increased by approximately $35,000, or 30.0%, compared to a 1,094.4% increase in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing gastroenterology rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Health Education

Summary of Findings

The Department found the payment rate for health education services was 62.4% of the benchmark; Colorado payments varied between 51.3%-1,058.2% of Medicare and an average of three other states' Medicaid rates. Of the nine procedure codes analyzed in this service grouping, two were compared to Medicare, and seven were compared to an average of five other states' Medicaid rates. States used in the health education rate comparison analysis were Arizona, Oklahoma, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding health education services in the 2022 reporting cycle.

Other considerations include:

- Health education services were reviewed in the 2018 Medicaid Provider Rate Review Analysis Report, as part of the Primary Care/E&M category of physician services.
- Health education services are optimal for migration to telehealth service provision.

Recommendations

The Department recommends:

1. Rebalancing health education rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Ophthalmology

Summary of Findings

The Department found the payment rate for ophthalmology services was 78.2% of the benchmark; Colorado payments varied between 12.2%-331.2% of Medicare and an average of six other states' Medicaid rates. Of the 49 procedure codes analyzed in this service grouping, 41 were compared to Medicare, and seven were compared to an average of six other states' Medicaid rates. States used in the ophthalmology rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

Themes of stakeholder feedback received during the 2022 reporting cycle included:

- Providers shared that the codes they use do not cover the cost of highly specialized and custom services.[1]

Other considerations include:

- Since ophthalmology services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, total expenditures increased by nearly $1 million, or 12.8%, compared to a 3.4% increase in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing ophthalmology rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.
2. Maintaining codes with a GT modifier over 100% of the benchmark at the current rate. The Department reimburses a transmission fee for codes with the GT modifier that is included in the current rate.

[1] Procedure codes for highly specialized and custom services are available to use for claims; the Department has recognized the need to share more information on appropriate codes for highly specialized and custom services.

3. Educating providers on appropriate codes for highly specialized and custom services.

Primary Care/Evaluation & Management (E&M)

Summary of Findings

The Department found the payment rate for primary care/E&M services was 83.2% of the benchmark; Colorado payments varied between 37.3%-194.0% of Medicare and an average of six other states' Medicaid rates. Of the 116 procedure codes analyzed in this service grouping, 90 were compared to Medicare, and 26 were compared to an average of six other states' Medicaid rates. States used in the primary care/E&M rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding primary care/E&M services in the public meeting. Committee members discussed some considerations for primary care/E&M services, particularly for improving access to care. Themes of committee feedback included:

- Community Integrated Health practices, if implemented, could help reduce patient intake times by conducting intake services during transportation to clinic or hospital, potentially increasing access to some physician services and primary care services.
- Opportunities to extend telehealth for applicable services to increase access for members and reduce costs to the Department.

Other considerations include:

- Since primary care/E&M services were reviewed in the 2018 Medicaid Provider Rate Review Analysis Report, total active primary care/E&M providers increased by 3,243, or 20.22%.
- Many of these services are being transitioned from in-person visits to telehealth visits due to improvements in technology that can be used for remote medical care.

Recommendations

The Department recommends:

1. Rebalancing Primary Care/E&M rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Radiology

Summary of Findings

The Department found the payment rate for radiology services was 90.6% of the benchmark; Colorado payments varied between 9.5%-389.0% of Medicare and an average of six other states' Medicaid rates. Of the 492 procedure codes analyzed in this service grouping, 482 were compared to Medicare, and 10 were compared to an average of six other states' Medicaid rates. States used in the radiology rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding radiology services in the 2022 reporting cycle.

Other considerations include:

- Since radiology services were reviewed in the 2018 Medicaid Provider Rate Review Analysis Report, the total active radiology providers continued to increase at a steady rate. In addition, total expenditures increased by over $5 million, or 19.4%, compared to a 12.6% decrease in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing radiology rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Respiratory

Summary of Findings

The Department found the payment rate for respiratory services was 97.5% of the benchmark; Colorado payments varied between 39.9%-141.8% of Medicare and an average of six other states' Medicaid rates. Of the 30 procedure codes analyzed in this service grouping, 28 were compared to Medicare, and two were compared to an average of six other states' Medicaid rates. States used in the respiratory rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding respiratory services in the 2022 reporting cycle.

Other considerations include:

- Since respiratory services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, Colorado reimbursement rates increased from 73.38% to 97.5% of the benchmark.
- Respiratory services were significantly impacted by the COVID-19 pandemic; for more information, see the supplemental analysis in Appendix F in the 2022 Medicaid Provider Rate Review Analysis Report.

Recommendations

The Department recommends:

1. Rebalancing respiratory rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Vaccines & Immunization

Summary of Findings

The Department found the payment rate for vaccines & immunization services was 107.9% of the benchmark; Colorado payments varied between 36.8%-284.7% of Medicare and an average of six other states' Medicaid rates. Of the 45 procedure codes analyzed in this service grouping, five were compared to Medicare, and 40 were

compared to an average of six other states' Medicaid rates. States used in the vaccines & immunizations rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding respiratory services in the 2022 reporting cycle.

Other considerations include:

- Vaccines & immunizations services were previously reviewed in the 2018 Medicaid Provider Rate Review Analysis Report, as part of the primary care/E&M service grouping.
- COVID-19 vaccination data is not included in this year's analysis base data, as the Department's data is limited to calendar year (CY) 2020 and earlier, due to requiring six months of claims run-out data at the time of starting the analysis.
- As has become clear during the COVID-19 pandemic, vaccine administration is critical to support our members' overall health and especially for reducing health disparities for low-income individuals.

Recommendations

The Department recommends:

1. Increasing vaccines & immunization rates that were identified to be below 80% of the benchmark to 80% of the benchmark.
2. Leave vaccines & immunization rates that were identified as above 80% at the current rate.

Vascular

Summary of Findings

The Department found the payment rate for vascular services was 121.2% of the benchmark; Colorado payments varied between 48.4%-310.7% of Medicare and an average of six other states' Medicaid rates. Of the 25 procedure codes analyzed in this service grouping, 23 were compared to Medicare, and two were compared to an

average of six other states' Medicaid rates. States used in the vascular rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

Themes of stakeholder feedback included:

- The vascular codes 36465 and 36466 for Varithena, which treats people with lower extremity vein problems, were approved by Medicare in 2018 and commercial insurers. Thousands of patients see outcomes from ablations or others and fare much better with this treatment. However, the level of reimbursement for these codes in Medicaid is significantly below the cost and may impact providing this service to Medicaid patients.[2]

Other considerations include:

- Since vascular services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, total expenditures increased by nearly $1 million, or 35.8%, compared to a 28.3% decrease in distinct utilizers.

Recommendations

The Department recommends:

1. Rebalancing vascular rates and evaluating 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.

Women's Health & Family Planning

Summary of Findings

The Department found the payment rate for women's health and family planning services was 83.4% of the benchmark; Colorado payments varied between 36.3%-194.3% of Medicare and an average of six other states' Medicaid rates. Of the 64 procedure codes analyzed in this service grouping, 43 were compared to Medicare, and 21 were compared to an average of six other states' Medicaid rates. States used

[2] Please note that these codes are under review in 2023 with surgical procedures, including vascular surgeries. This feedback will be considered during the 2023 reporting cycle.

in the women's health and family planning rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

Themes of stakeholder feedback included:

- Stakeholders shared in the public meetings, that the rate for abortion services has not changed since the 1990s and is set too low for appropriate member access and provider retention for these services.[3]
- Opportunities exist to extend telehealth for applicable services to increase access for members and reduce costs to the Department, particularly for primary care/E&M, health education, and family planning services, among others.

Other considerations include:

- Family planning and women's health services are comprised of mostly preventive care services, and family planning is pushed heavily at a national level.

Recommendations

The Department recommends:

1. Rebalancing women's health and family planning rates 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. [4]
2. Maintaining codes with a GT modifier over 100% of the benchmark at the current rate. The Department reimburses a transmission fee for codes with the GT modifier that is included in the current rate.
3. Increasing E&M rates with the FP modifier services rates to align with the same service rates paid to other provider types.

[3] This service is scheduled to be reviewed in the 2023 review.
[4] Procedure code 58300 was not included in the original analysis and will be included in the rebalance as it was under the 80% benchmark threshold.

Other Physician Services

Summary of Findings

The Department found the payment rate for other physician services was 83.7% of the benchmark; Colorado payments varied between 4.0%-429.4% of Medicare and an average of six other states' Medicaid rates. Of the 265 procedure codes analyzed in this service grouping, 221 were compared to Medicare, and 44 were compared to an average of six other states' Medicaid rates. States used in the other physician services rate comparison analysis were Arizona, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding other physician services in the 2022 reporting cycle.

Other considerations include:

- Since other physician services were reviewed in the 2018 Medicaid Provider Rate Review Analysis Report, both total members accessing other physician services and total active other physician services providers increased. In addition, total expenditures increased by over $300 million, or 35.0%, compared to a 10.1% decrease in distinct utilizers.
- The other physician services grouping included additional codes in the 2022 analysis, compared to the previous review in the 2018 Medicaid Provider Rate Review Analysis Report.

Recommendations

The Department recommends:

1. Rebalancing other physician services rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Dialysis & Nephrology Services

Summary of Findings

Facility-Based Payments

The Department found the payment rate for dialysis facility-based services was 78.5% of the benchmark; Colorado payments varied between 75.5%-80.2% of Medicare regional rates. All revenue codes analyzed in this service grouping were compared to Medicare.

Professional Procedure Codes

The Department found the payment rate for dialysis professional services was 61.1% of the benchmark; Colorado payments varied between 26.9%-104.0% of Medicare and an average of three other states' Medicaid rates. Of the 19 procedure codes analyzed in this service grouping, 18 were compared to Medicare, and one was compared to an average of three other states' Medicaid rates. States used in the dialysis professional services rate comparison analysis were Arizona, Nevada, and Oregon.

Key Considerations

The Department did not receive any feedback from stakeholders regarding dialysis facility-based services during the 2022 reporting cycle.

Other considerations include:

- Since dialysis facility services were reviewed in the 2019 Medicaid Provider Rate Review Analysis Report, expenditures increased by over $1 million, or 11.6%, compared to a 24.1% increase in distinct utilizers.
- Dialysis facility members become eligible for Medicare after three months of receiving Medicaid dialysis facility services.
- Since dialysis professional services were reviewed in the 2019 Medicaid Provider Rate Review Analysis Report, both total members accessing dialysis professional services and total active dialysis professional providers increased. In addition, dialysis professional total expenditures increased by over $800,000, or 1,415.7%, compared to a 13.2% increase in distinct utilizers.

- This year's dialysis professional service grouping was comprised of 19 procedure codes, compared to only five procedure codes analyzed in 2019, which accounts for the significant increase in total expenditures since these services were first reviewed.

Recommendations

Facility-Based Payments

The Department recommends:

1. Increasing dialysis facility-based services rates to 80% of the benchmark.
2. The Department will continue to work to identify the correct primary payer and help to facilitate the billing of the correct payer.

Professional Procedure Codes

The Department recommends:

1. Increasing dialysis professional services rates to 80% of the benchmark.
2. The Department will continue to work to identify the correct primary payer and help to facilitate the billing of the correct payer.

Laboratory & Pathology Services

Summary of Findings

The Department found the payment rate for laboratory & pathology (laboratory) services was 93.7% of the benchmark; Colorado payments varied between 6.9%-178.3% of Medicare and an average of seven other states' Medicaid rates. Of the 984 procedure codes analyzed in this service grouping, 963 were compared to Medicare, and 21 were compared to an average of seven other states' Medicaid rates. States used in the laboratory & pathology (laboratory) services rate comparison analysis were Arizona, California, Oklahoma, Nebraska, Utah, Nevada, and Oregon.

Key Considerations

Other considerations include:

- Both total members accessing laboratory services and total active laboratory providers increased from CY 2019 to CY 2020, despite the impact of the COVID-19 pandemic.
- Laboratory services providers perform tests and bill for that service; they do not order, collect, or interpret the results of the tests.
- In claims data, providers are assigned an identification code based on their billing location, which may impact the laboratory services drive time analysis, as services may be provided at multiple locations, but will appear as one location based on the billing provider's claims data.
- Providers are not required to report the number of employees or details about facility capabilities to the Department. As such, claims data may not accurately represent a provider's capacity, or whether an individual laboratory performed at, over, or under capacity.
- Some laboratory services are subject to an Upper Payment Limit (UPL), which limits the rate to 100% of the Medicare rate or lower.

Recommendations

The Department recommends:

1. Rebalancing laboratory service rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Eyeglasses & Vision Services

Summary of Findings

The Department found the payment rate for eyeglasses & vision (vision) services was 57.4% of the benchmark; Colorado payments varied between 14.0%-192.0% of Medicare and an average of six other states' Medicaid rates. Of the 109 procedure codes analyzed in this service grouping, 99 were compared to Medicare, and ten were compared to an average of six other states' Medicaid rates. States used in the eyeglasses & vision (vision) services rate comparison analysis were Arizona, California, Oklahoma, Louisiana, Nevada, and Oregon.

Key Considerations

Other considerations include:

- Vision service policy allowances and limits vary for adults (21 years of age and older) and children (0-20 years of age), which may impact utilization of these services. Adults are not eligible for eyeglasses or contact lenses except after eye surgery.
- Several procedure codes in the vision service grouping that were previously compared to an average of other states' Medicaid rates were identified as having comparable rates on the Medicare durable medical equipment (DME) fee schedule, which account for the significant change in Colorado's repriced amount compared to the benchmark in the rate comparison analysis.

Recommendations

The Department recommends:

1. Rebalancing vision service rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.
2. Increase eyeglasses and frames rates for children and adults who have had qualifying surgery to 80% of the benchmark.

Injections & Miscellaneous J-Codes

Summary of Findings

The Department found the payment rate for injections & miscellaneous J-codes was 95.6% of the benchmark; Colorado payments varied between 5.0%-184.9% of Medicare and an average of four other states' Medicaid rates. Of the 12 procedure codes analyzed in this service grouping, nine were compared to Medicare, and three were compared to an average of four other states' Medicaid rates. States used in the injections & miscellaneous J-codes rate comparison analysis were California, Nebraska, Utah, and Oregon.

Key Considerations

Other considerations include:

- Most services under this service grouping were moved under the pharmacy benefit to undergo regular rate setting analyses that align with other pharmacy processes. The injection service grouping is included to ensure the remaining

codes from the PADs service grouping that do not undergo periodic reviews are still reviewed on a consistent basis.

Recommendations

The Department recommends:

1. Rebalancing Injection & Miscellaneous J-Code rates that were identified to be below 80% of the benchmark and above 100% of the benchmark.

Out-of-Cycle Reviews

The Joint Budget Committee (JBC) requested that the Department compare outpatient physical therapy/occupational therapy (PT/OT) and speech therapy (ST) to home health PT/OT and ST. The Department was able to determine the amount paid per provider per day for PT/OT and ST and compared this to the per diem rate paid for home health PT/OT and ST. The committee also requested a review of outpatient hospital specialty drugs.

Summary of Findings

Physical & Occupational Therapy (PT/OT)

The Department found the payment rate for PT/OT services was 91.0% of the benchmark; Colorado payments varied between 29.2%-175.8% of Medicare and an average of seven other states' Medicaid rates. Of the 45 procedure codes analyzed in this service grouping, 40 were compared to Medicare, and five were compared to an average of seven other states' Medicaid rates. States used in the PT/OT services rate comparison analysis were Arizona, California, Oklahoma, Maine, Michigan, and Oregon.

Speech Therapy (ST)

The Department found the payment rate for speech therapy services was 79.0% of the benchmark; Colorado payments varied between 17.4%-89.0% of Medicare and an average of five other states' Medicaid rates. Of the 21 procedure codes analyzed in this service grouping, 20 were compared to Medicare, and one was compared to an average of five other states' Medicaid rates. States used in the speech therapy

services rate comparison analysis were Arizona, California, South Carolina, Nevada, and Minnesota.

Home Health PT/OT/ST

The Department found the payment rate for home health PT/OT/ST services was 100.2% of the benchmark; Colorado payments varied between 90.3%-111.9% an average of 11 other states' Medicaid rates. All the revenue codes analyzed in this service grouping were compared to an average of 11 other states' Medicaid rates. States used in the home health PT/OT/ST services rate comparison analysis were California, Nebraska, Oregon, Idaho, Illinois, Louisiana, Maryland, North Carolina, Ohio, Washington, and Wisconsin.

Outpatient Hospital Specialty Drugs

The Department payment policy for outpatient hospital specialty drug services was 72% of the benchmark.

Key Considerations

Other considerations include:

- Utilization trends in data indicate a migration of PT/OT and speech therapy services from individual speech therapy providers to home health agencies, which provide a wider range of services for individuals needing more comprehensive home health care.
- The Department calculated that approximately 24.8% of long-term Home Health PT/OT utilizers also received long-term HH nursing/CNA care. Similarly, 16% of long-term Home Health Speech Therapy utilizers received long-term HH nursing/CNA care.
- Home health agencies have more requirements and administrative costs compared to individual PT/OT and speech therapy providers, which are factored into home health rates.
- Most visits for PT/OT and speech therapy services include more than one procedure code.

- PT/OT and speech therapy outpatient rates were rebalanced to 80 - 100% of the benchmark rate as of July 1, 2022. Home Health PT/OT/ST rates were all above the 80% benchmark rate.

Recommendations

Home Health PT/OT/ST

The Department will continue to investigate opportunities to align rate reimbursement methodologies across similar services.

Outpatient Hospital Specialty Drugs

The Department has implemented an increase to the reimbursement methodology from 72% to 90% of the hospital's invoice net of rebates and discounts.