MPRRAC Meeting

November 16, 2018
10:00 AM – 11:30 AM

Facilitator – Kimberley Smith

COLORADO
Department of Health Care Policy & Financing

Agenda

Meeting Minutes Review	10:00 – 10:05 AM
Update: Year 3 Rate Recommendations	10:05 – 10:10 AM
Introduction to Year 4 Services	10:10 – 10:50 AM
Stakeholder Comment	10:50 – 11:00 AM
Discuss Any Changes to Year 4 Schedule	11:00 – 11:10 AM
Discuss Term Limits & Year 4 Meeting Schedule	11:10 – 11:30 AM

Meeting Minutes Review

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Update: 2018 Rate Recommendation Report

The 2018 Medicaid Provider Rate Recommendation Report was submitted to the MPRRAC and the Joint Budget Committee on November 1st.

Department recommendations were as follows:

- A budget-neutral rebalancing of certain individual evaluation & management and primary care, radiology, and physical therapy rates with payments below 80% and above 100% of the benchmark.
- An increase to maternity service rates, not to exceed 80% of the benchmark.
- An increase to certain preventive dental service rates.

Year Four Services

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Adjustments to Year Four Rate Review Schedule

The Rate Review Schedule is found on the MPRRAC website.

Last year, the Department made the following changes to the Year Four Rate Review Schedule:

- Moved review of family planning services to year three (instead of year four);
- Moved review of durable medical equipment (DME) to year four (instead of year three);
- Moved review of Health and Behavior Assessment and psychiatric treatment codes to year four (instead of year three).

Year Four Rate Review Schedule

Service, facility and equipment rates under review this year include:

- Behavioral Health Services, including:
  - Psychiatric treatment services and other mental and substance use disorder services not otherwise covered by the Regional Accountable Entity
  - Residential Child Care Facility (RCCF) services and facility payment to Psychiatric Residential Treatment Facility (PRTF)
- Payments to Ambulatory Surgical Centers
- Payments to Dialysis Centers
- Durable Medical Equipment

Behavioral Health Services

- Behavioral health assessment, psychiatric treatment, and other mental health and substance use disorder services for diagnoses not otherwise covered by the Regional Accountable Entity, such as Autism and Gender Identity Disorder.

  - A majority of behavioral health services are <u>not</u> reimbursed fee-for-service; they are reimbursed through the capitated behavioral health program.

- In FY17, utilizers of behavioral health services reimbursed fee-for-service were largely adults, many of whom were age 65+ (Medicare cross-over services).

- Note: Services under review this year include the Special Connections Program, substance use disorder treatment for women who are pregnant and parenting through the first year postpartum. These services include assessment, outpatient services and a residential benefit.

Behavioral Health Services – Residential Child Care Facility (RCCF)

- Residential treatment services for (primarily child welfare involved) youth, carved out of the capitated behavioral health program because of high needs.

- Utilizers are small in number, under age 21, and typically have high acuity, trauma related diagnoses.

- CDHS overseeing implementation of Family First Preservation Services Act of 2017, which will require these facilities to meet additional service requirements by October 1, 2019.

Behavioral Health Services – Psychiatric Residential Treatment Facility (PRTF)

- Residential treatment service for youth who require 24-hour medical care, carved out of the capitated behavioral health program because of high needs.

- Utilizers are small in number, under age 21, and typically have complex needs, including developmental challenges (higher acuity than RCCF).

- The PRTF rate is a single, per diem facility payment. It is inclusive of all service provided to the child in the facility by facility staff. Services provided outside the facility, or by non-facility staff, are billed separately as fee-for-service.

  - Examples of fee-for-service claims that may be billed separately may include Dental or Vision services.

- Family First Preservation Services Act medical requirements on RCCFs may change the role of PRTFs in the service continuum in the near future.

Ambulatory Surgery Center Services

- ASCs are distinct entities that provide a surgical setting for members who do not require hospitalization.

- Services performed at an ASC are assigned to one of ten rate group brackets for the purpose of reimbursement. For example:

  - Excision of a malignant lesion between 3.1 cm and 4.0 cm is attributed to ASC Group 2 and pays at $358.73

  - Rhinoplasty related to congenital cleft lip/palate is attributed to ASC Group 9 and pays at $1,077.13

- If multiple procedures are provided in a single visit, they are “grouped” together and reimbursement is based on the most complex procedure.

- ASC reimbursement includes related services and items, such as use of facilities, nursing services, blood products, and items directly related to the provision of surgical procedures.

Dialysis and End-Stage Renal Disease Services

- Services under review this year include:
  - ➢ Facility payment to Dialysis Centers for dialysis treatment.
  - ➢ A few procedure codes relating to patient training and home dialysis (90937, 90989, 90993, 90963, 90966)
- Dialysis treatment performed at Dialysis Centers is “bundled” into a single per diem facility payment, which differs based on the county where the dialysis center is located.
- Medicaid coverage of dialysis is limited to three months; on the fourth month of dialysis members become eligible for Medicare.

Durable Medical Equipment

- DME includes medical equipment that can withstand repeated use and that generally would be of no value to the member in the absence of a disability, illness or injury.

  - Examples of DME include wheelchairs, hospital beds, and oxygen concentrators.

  - Note: Prosthetics and disposable supplies are scheduled for review in Year Five of the Rate Review process

- Effective July 1, 2017, DME providers were approved for a 1.4% across the board rate increase. However, Federal legislation required states and the Centers for Medicare and Medicaid Services (CMS) to set certain DME rates at 100% of Medicare reimbursement, ultimately cutting rates for many of the codes under review.

[Insert TRI bullet]

Stakeholder Comment

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Year Four Schedule and Next Steps

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Changes to Year 4 Review Schedule

Committee recommendations to change those services under review this year must be made prior to December 1, 2018.

Services that remain to be reviewed (in Year 5 of the Rate Review process) include:

- DME: Prosthetics & Orthotics
- DME: Disposable Supplies
- Eyeglasses

Term Limits and Year 4 Meeting Schedule

Term Limits

- Committee member terms are four years in length
- The terms of most members will end in September of 2019
- Committee members can be reappointed

2019 Meeting Schedule

- The Department proposes convening MPRRAC meetings in February, March, June, and September