COLORADO
Department of Health Care Policy & Financing

FY 2015-16 Provider Rate Increases Approved by the General Assembly

Provider Frequently Asked Questions

Across The Board Rate Increases

1. When will the across-the-board rate increases be in effect?

Across-the-board rate increases will be effective July 1st. Implementation of increased payments will occur following: 1) Federal approval and 2) Loading the all new rates into the Medicaid Management Information System (MMIS), which may take 4-6 weeks following federal approval.

2. What does a provider need to do to get the increase (is there paperwork or an attestation)?

No paperwork or attestation is required by providers. Once rates that received increases are updated in the MMIS, providers billing the rate will automatically receive the increase.

3. How does a provider get paid if the process is delayed and the rate increases aren't implemented on 7/1/2015?

The Department is working hard to implement the rates before 7/1/2015. However, providers will be paid retroactively if there is a delay in implementation.

Providers billing usual and customary charges greater than the 7/1/2015 rate, for services provided on or after 7/1/2015, will be paid the difference through a mass adjustment process once the new rates have been loaded into the MMIS. For providers billing usual and customary charges that are less than the 7/1/2015 rate increase, however, the provider will be required to void previously submitted claims with the lower rate and resubmit claims with the increased rate.

4. Does every provider group qualify for an across the board increase?

Although these rate increases affect most Medicaid providers, a number of providers are exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of physician and EPSDT services are not eligible for an increase in rates due to rates already being increased under Section 1202 of the Affordable Care Act and subsequently continued under state authority.
- A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract.
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement.
- Reimbursements to pharmacies are not eligible for the rate increase. Pharmaceutical reimbursement transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase.
- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated.

- Rates for Federally Qualified Health Centers are ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology.
- Rates for services provided under the home and community based services (HCBS) waiver for children with autism would be ineligible because of the cap on client expenses. An increase in rates would reduce the amount of services that clients are able to receive. For this reason, the Department has not applied rate reductions to this program in prior years and would not apply a rate increase to the reimbursement of these services.
- Class I and Class II nursing facility rates are determined in accordance with statutory guidelines which has the effect of increasing reimbursement to most providers each year, based on providers' cost. In addition, the Department would exempt hospice rates that are set in part as a function of nursing facility rates and in part as a result of federal requirements. Hospice rates that are not related to nursing facility rates are included in the Department's proposal.
- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may or may not be impacted by rate increases.
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan *Plus* (CHP+) and behavioral health organizations (BHO) do not receive direct rate increases as part of this change request.

Targeted Rate Increases

5. When will the targeted rate increases be in effect?

Targeted rate increases will be effective July 1st. Implementation of increased payments will occur following: 1) Federal approval, and 2) Loading the new rates into the Medicaid Management Information System (MMIS), which takes 4-6 weeks following federal approval. Federal approval received after 7/1/2015 will be effective retroactively to the effective date.

6. What do providers have to do to get the targeted rate increases?

No action is required by providers to receive the rate increase. When the rate increases are approved and loaded into the MMIS, submitted claims for services provided on or after 7/1/2015 will be paid at the new rate.

7. How does a provider get paid if the process is delayed and the rate increases aren't implemented on 7/1/2015?

The Department is working hard to implement the rates before 7/1/2015. However, providers will be paid retroactively if there is a delay in implementation.

Providers billing usual and customary charges greater than the 7/1/2015 rate, for services provided on or after 7/1/2015, will be paid the difference through a mass adjustment process once the new rates have been loaded into the MMIS. For providers billing usual and customary charges that are less than the 7/1/2015 rate increase, however, the provider will be required to void previously submitted claims with the lower rate and resubmit claims with the increased rate.

8. Will every provider group get a targeted rate increase this year?

Providers whose services include those rates included in the targeted rate increases approved by the General Assembly will receive the increases. The Department has developed a Fact Sheet with information about the approved increases.

9. Why did some rates get increases and others did not?

The Department published a request to providers and other stakeholders on December 1, 2014 to submit rate increase proposals to help the Department identify rate inequities as well as rate improvements that would improve access to care and health outcomes. Proposals were accepted over a 5-week submission period, and then were evaluated against published criteria. Those meeting the criteria and approved by Department leadership were forwarded to the Joint Budget Committee for approval of the General Assembly. Additional rate increases were identified and approved by the General Assembly.

Rate Reviews Next Year

10. Will there be a targeted rate increase process next year (for FY 2016-17)?

With the passage of SB 15-228 in the recent legislative session, the General Assembly created an annual review process for Medicaid rates. The process will provide an ongoing forum for providers and other stakeholders to provide input on rates and the review process.

11. What can providers do to get involved with the rate review process?

Specific members of the legislature as described in SB 15-228 will appoint representatives to make up the Advisory Committee to participate in and consult on the rate review process. These members include: Senate President, Senate Minority Leader, House Speaker, and the House Minority Leader. The Advisory Committee is expected to meet quarterly, and will provide a forum for feedback on rates and the rate review process.