November 1, 2007

The Honorable Abel Tapia, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Tapia:

This letter is in response to footnote 24 of Senate Bill 07-239, which states:

> Senate Bill 07-239, Footnote 24
> *Department of Health Care Policy and Financing, Executive Director's Office, Primary Care Provider Rate Task Force and Study -- The Department is requested to work with the provider community to examine any issues of rate disparity and rate shortfalls for physician and acute care providers. The Department is requested to report on its final analysis by November 1, 2007. The Department's appropriation contains $19,334 total funds for the expenses of any task force that the Department may assemble and for temporary staffing costs for conducting such a study.*

As you are aware, footnote 24 of Senate Bill 07-239 was vetoed by the Governor because it violated the separation of powers in Article III of the Colorado Constitution by attempting to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriations bill. The Governor did instruct the Department to comply to the extent feasible.

The Department contracted with Navigant Consulting for the purpose of conducting an analysis of existing Medicaid rates for physician and other acute care services to identify areas of rate disparities and rate shortfalls. The contract with Navigant Consulting also included facilitating the Primary Care Provider Rate Task Force in review and analyzes of the rate disparities and shortfalls identified in the data analysis, coordinate discussion among the task force members and summarize the recommendations of the Task Force in a final report.

Attached is the final report by Navigant Consulting titled, “Colorado Provider Rate Task Force – Recommendations Regarding Medicaid Physician and Other Practitioner Reimbursement”. This report summarizes the findings of the Medicaid rate analysis and the recommendations of the Primary Care Provider Rate Task Force. The Department participated in the task force meetings in an advisory capacity; however the recommendations contained in the report were developed by the physician and acute care providers who participated on the task force. The Department

will continue to work with the task force and internally to develop an implementation plan that details the steps needed to advance the task force recommendations and other considerations related to this issue. The implementation plan will include incremental steps towards applying the uniform reimbursement methodology for all services and a mechanism to periodically evaluate and maintain rate adjustments to avoid rate disparities and rate shortfalls in the future.

Questions regarding this response to footnote 24 of Senate Bill 07-239 can be addressed to Margaret Mohan, Manager, Acute Care Benefits Section at (303) 866-5620.

Sincerely,

Joan Henneberry
Executive Director

JH/tk

Attachment: Colorado Provider Rate Task Force Final Report – Recommendations Regarding Medicaid Physician and Other Practitioner Reimbursement

Cc: Representative Bernie Buescher, Vice-Chairman, Joint Budget Committee
Senator Moe Keller, Joint Budget Committee
Senator Steve Johnson, Joint Budget Committee
Representative Jack Pommer, Joint Budget Committee
Representative Al White, Joint Budget Committee
Senator Joan Fitz-Gerald, President of the Senate
Senator Ken Gordon, Senate Majority Leader
Senator Andy McElhany, Senate Minority Leader
Representative Andrew Romanoff, Speaker of the House
Representative Alice Madden, House Majority Leader
Representative Mike May, House Minority Leader
John Ziegler, JBC Staff Director
Melodie Beck, JBC Analyst
Todd Saliman, Director, Office of State Planning and Budgeting
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Ginny Brown, Legislative Liaison/Public Information Officer
HCPF Budget Library, HCPF Division

# COLORADO PROVIDER RATE TASK FORCE

## *Recommendations Regarding Medicaid Physician and Other Practitioner Reimbursement*

**September 26, 2007**

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**Colorado Department of Health Care Policy and Financing**

## EXECUTIVE SUMMARY

The Colorado Legislature charged the Colorado Department of Health Care Policy and Financing (the Department) through Colorado House Bill 06-1385, footnote 22 to examine the fee-for-service reimbursement rates it pays to physicians and other practitioners:

> *Department of Health Care Policy and Financing, Executive Director's Office, Primary Care Provider Rate Task Force and Study – The Department is requested to work with the provider community to examine any issues of rate disparity and rate shortfalls for physician and acute care providers. The Department is requested to report on its preliminary findings by November 1, 2006 and its final analysis by November 1, 2007.*

The Department engaged Navigant Consulting, Inc. to conduct a study of the existing Medicaid physician fee schedule and payments and to facilitate meetings of the Primary Care Provider Rate Task Force ("Task Force"), which was convened pursuant to the House Bill.

Currently, Colorado Medicaid pays physicians and other practitioners based on a fee schedule that was first established based on commercial insurance payments and over the years, updated through increases to various targeted services. Following a fee decrease in State Fiscal Year (SFY) 2003, a marginal increase in SFY 2004 and no increase in SFY 2005, Medicaid increased selected fees two percent in SFY 2006 and increased selected fees again in SFY 2007 by 3.25 percent. For SFY 2008, Colorado Medicaid increased rates for anesthesia, surgery, therapeutic services, adult immunization, durable medical equipment repair and Paraguard contraceptive services.

During its meetings, the Task Force reviewed analyses of historical paid claims data and identified a number of issues related to physician reimbursement, Medicaid reform and other concerns regarding the Medicaid program.

When discussing the effect of rate shortfalls and disparities on provider participation, the Task Force considered analyses that showed payments to both primary care providers and specialists. Briefly, the Task Force discussed that Medicaid payment levels do not promote access to quality services and do not assure availability of specialists to whom clients can be referred.

Task Force members indicated that there are variances in fee schedule amounts that are not rational. In addition, they indicated that it is not only the level of payments, but other factors, such as administrative requirements regarding billing the Medicaid program, that contribute to provider decisions to not participate in the Medicaid program. In addition, some providers reported that other administrative requirements, such as the processes related to the Vaccines for Children program, were cumbersome and time-intensive.

After a series of deliberations, the Task Force made several recommendations about physician and other practitioner reimbursement. The Task Force unanimously voted to make the following major recommendations:[1]

- Increase Medicaid fees for physicians and other practitioners to levels that approximate commercial insurance payments. The Task Force rejected using Medicare as a benchmark because Medicare payment levels are subject to policy adjustments and political pressure. Commercial rates as a percent of Medicare vary by state, however, Task Force members estimated that commercial payments generally range from 110 percent to 140 percent of Medicare.

- Implement Medicare's Resource-Based Relative Value System (RBRVS) fee schedule methodology for physician and other practitioner services. Pay for anesthesia services using the relative value scale that Medicare uses and that is based on relative values published by the American Society of Anesthesiologists. The Task Force recommended that this conversion factor be calculated to yield an amount that approximates commercial payment levels. They further recommended that Medicaid pay for laboratory services using the current Medicare methodology. The Task Force also made other recommendations about the implementation of RBRVS that are detailed further in this report.

- Implement a fee schedule for durable medical equipment that is based on the Medicare methodology.

- Implement a fee schedule for drugs that are not self-administered (i.e., injections) that is based on the Medicare methodology.

In addition to the recommendations that the Task Force made regarding implementation of an RBRVS fee schedule, the Navigant Consulting team identified a number of other administrative, technical and implementation issues that the Department should consider if it moves to the RBRVS approach. These, too, are described in greater detail in the following pages.

Task Force members also discussed at length whether the members should make recommendations to the Department about interim steps to achieve a fee schedule that would pay rates that approximate commercial rates. This was based on some Task Force members' assumptions that the Legislature would not support the recommendation to increase rates to commercial payment levels (which is estimated by Navigant Consulting, based on approximate fee-for-service expenditure estimates from the Department, to cost the state more than $174 million in State funds) in one step.[2] Almost one-half of the Task Force members supported a

[1] These recommendations reflect the opinions of the Task Force, and are not necessarily those of the Department.
[2] Any approved budget appropriation could not take place until SFY 2009, at the earliest. All expenditure estimates are reported in SFY 2006 dollars, and have not been inflated forward. Also, this estimate does not account for any changes in service utilization or the number of Medicaid recipients.

recommendation for an interim adjustment that addresses the current payment disparities by type of CPT code, with an emphasis on Evaluation and Management CPT codes. These Task Force members did not have enough votes to constitute a majority, and therefore, this interim step is not issued as a formal recommendation.

The Task Force also made recommendations about issues that affect physician and other practitioner reimbursement, but are greater in scope than the charge to the Task Force. These recommendations were discussed at length, and the Task Force, Department and Navigant Consulting facilitators determined that some of these recommendations are currently being addressed elsewhere, and that some recommendations should be addressed to other State entities. These recommendations are:

- Implement incentives for Medicaid patients to seek care and follow healthy behaviors through a Medical Home Model. Task Force members indicated their concern that Medicaid beneficiaries are not always using resources appropriately and that there could potentially be significant savings that could fund physician and other practitioner fee increases if a Medical Home Model were implemented for Colorado Medicaid. Very simply stated, the premise behind the Medical Home Model is that care will be improved if patients have direct access to a medical facility or a physician who accepts responsibility for their care and practices in a system organized to support better care.

- Consider the use of Medicaid waivers to implement some changes, such as guaranteed eligibility time spans for Medicaid consumers. This would allow providers to provide continuity of care for Medicaid patients.

## SECTION I: INTRODUCTION

The Colorado Legislature charged the Colorado Department of Health Care Policy and Financing (the Department) through Colorado House Bill 06-1385, footnote 22 to examine the fee-for-service reimbursement rates it pays to physicians and other practitioners:

> *Department of Health Care Policy and Financing, Executive Director's Office, Primary Care Provider Rate Task Force and Study – The Department is requested to work with the provider community to examine any issues of rate disparity and rate shortfalls for physician and acute care providers. The Department is requested to report on its preliminary findings by November 1, 2006 and its final analysis by November 1, 2007.*

The Department complied with the intent of this bill by:

- Engaging Navigant Consulting, Inc. to conduct a study of the existing Medicaid physician fee schedule and payments
- Convening the Primary Care Provider Rate Task Force ("Task Force") to review the Medicaid physician fee schedule study and provide comment regarding payment disparity and shortfalls

The study and this paper focus on the Medicaid providers that are paid according to the Colorado Medicaid physician fee schedule. This includes physicians, as well as non-physician practitioners (e.g., physician assistants, nurse practitioners, certified registered nurse anesthetists) and other providers (e.g., optometrists, podiatrists). We refer to this collection of providers as "physicians and other practitioners."

This report contains a description of the current fee schedule methodology used by Colorado Medicaid, a discussion of the fee schedule methodologies used by Medicare and select other states' Medicaid programs, a summary of the findings from the paid claims analyses, an account of the Task Force meetings and a summary of the Task Force recommendations.

# SECTION II: CURRENT FEE SCHEDULE METHODOLOGY FOR PHYSICIANS AND OTHER PRACTITIONERS

This section describes the current fee schedule methodology for physicians and other practitioners who contract with Colorado Medicaid.

## Colorado Fee Schedule Methodology

The Department reimburses services provided by physicians and other practitioners at the lower of either the provider's charge or the fee schedule amount. The physician fee schedule is a list of CPT (Common Procedural Terminology) codes and definitions, and relative values, and "system parameters" that identify the conversion factor to use for each code.

The Department calculates the fee schedule amount by multiplying one of six conversion factors by the associated unit values for a service. Colorado originally established a method for updating the conversion factor based on commercial insurance payments (historically, the 90th percentile of basic BlueShield plans), the current unit value for each current procedural terminology (CPT) service code (based on the 1971 relative value scale published by the Centers for Medicare and Medicaid Services) and Department input.

With the State's cost containment efforts in recent years, however, Colorado has not issued systematic conversion factor updates to the fee schedule, and has instead made targeted fee reductions or increases to specific CPT codes as needed. Analyses performed by the State of Colorado that show that the State Fiscal Year (SFY) 2006 fee index comparing Colorado Medicaid to Medicare rates ranged from 302.67 (i.e., more than 3,000 percent of Medicare) for A4422 (ostomy pouch absorbent material) to .0016 (i.e., 1.6 percent of Medicare) for CPT 46610 (anoscopy, remove lesion).[1]

To comply with budget limits, the Department implemented some provider rate reductions, along with other programmatic and administrative cost containment measures, in SFY 2003. The Department did not reduce the physician fee schedule rates at that time. As a way to increase provider rates using a budget neutral approach, the Department eliminated a provider incentive payment to grant a procedure code increase in SFY 2004, and then held physician fee schedule rates constant in SFY 2005. Since SFY 2006, the Department has instituted two consecutive rate increases for physicians: a 2 percent increase in SFY 2006 (targeting the top nine Evaluation and Management codes), and a 3.25 percent increase in SFY 2007 (targeting the top 25 Evaluation and Management codes). For SFY 2008, Colorado Medicaid increased rates for anesthesia, surgery, therapeutic, adult immunization, durable medical equipment repair and Paraguard contraceptive services, as summarized in Table 1.

[1] Analysis performed by Health Care Policy and Financing Business Analysis Section, May 2006.

### Table 1: SFY 2008 Colorado Medicaid Rate Increases

| Category | Appropriation |
|---|---|
| Anesthesia | $3,150,000 |
| Surgical procedures | $1,650,000 |
| Physical, occupational and speech | $1,000,000 |
| Adult immunizations | $600,000 |
| DME repairs | $500,000 |
| Intrauterine devices | $90,000 |

## SECTION III: MEDICARE AND OTHER PAYERS' FEE SCHEDULE APPROACHES

In addition to our review of Colorado's methodology, we also reviewed the methodologies used by Medicare, commercial insurers and other State Medicaid programs to understand how Colorado Medicaid compares to other payers.

### Medicare

Many state Medicaid programs model their policies after Medicare's policies and reimbursement systems. Medicare reimburses physicians, independent radiologists, physical and occupational therapists, optometrists and nurse practitioners according to the resource-based relative value scale (RBRVS) system. Medicare adopted the RBRVS, which is based on the estimated cost of resources required to provide services, in accordance with the Omnibus Budget Reconciliation Act of 1989. This methodology was fully phased in for Medicare payment purposes on January 1, 1996. The Centers for Medicare and Medicaid Services updates the conversion factor annually, the relative values periodically and the geographic practice indices every three years.

The RBRVS system has two main components: a Relative Value System (RVS) and a conversion factor. Compared to other systems, RBRVS-based systems generally result in higher fees for CPT Evaluation and Management, Medicine and Maternity procedures relative to the rest of the fee schedule.

The RVS assigns values to physician procedures called relative value units (RVUs) that reflect the resource utilization required for each service. The RVS comprises three cost components, and the values assigned to each component are added together to equal the total units for each service:

- **Physician Work** – As measured by the time and intensity of the physician's effort in providing a service, including activities before and after direct patient contact. For surgical procedures, physician work is based on a global definition that includes pre-operative and post-operative consultations and services.

  The physician work component is measured quantitatively and qualitatively along four parameters:

  - Time required to perform the service, as measured in minutes
  - Technical skill and physical effort
  - Mental effort and judgment

  - Physician stress due to the possibility of secondary complications as a result of the initial procedure; this component also includes a measure of the skill and training necessary to provide the service

- **Practice Expense** – Costs of items such as office rent, salaries, equipment and supplies.

- **Malpractice Expense** – professional liability insurance premium expenses associated with furnishing physician services.

The RBRVS conversion factor converts the relative value units for a particular procedure to an actual dollar amount. The Centers for Medicare and Medicaid Services issue updates to the conversation factor annually based on:

- The Medicare economic index

- An expenditure target based on Medicare's sustainable growth rate

- Other adjustments, including budget neutrality adjustments

RBRVS also includes factors to account for geographic differences in practice costs, as measured by the geographic practice cost index (GPCI) published by the Centers for Medicare and Medicaid Services. There is a GPCI for three components of the fee schedule:

- GPCI Practice compares local practice expenses with national average practice expenses

- GPCI Malpractice compares local malpractice insurance premiums with the national average

- GPCI Work compares physician work effort in the local area with the comparable national average

Using all of these components (i.e., the RVS, the conversion factor and the GPCI), payers calculate the RBRVS fee for each specific procedure or service as follows:

*{(RVU Work * GPCI Work) + (RVU Practice * GPCI Practice) +*
*(RVU Malpractice * GPCI Malpractice)} * Conversion Factor = RBRVS Fee*

## Medicare Fee Schedule for Anesthesiology Services

Medicare excludes anesthesiology services from the RBRVS payment approach and pays for these services based on allowable base unit values that reflect all activities other than anesthesia time. Medicare's values are based on the American Society of Anesthesiologists' Relative Value Guide, with some modifications. These relative values are multiplied by the number of units of

anesthesia time (the time that the anesthesiologist is present with a patient) and an anesthesia-specific conversion factor.

### Medicare Fee Schedule for Durable Medical Equipment

Medicare payment for durable medical equipment, as well as prosthetics and orthotics, parenteral and enteral nutrition, surgical dressings and therapeutic shoes and inserts (collectively referred to as DMEPOS) is equal to 80 percent of the lower of either the actual charge for the item or the Medicare DMEPOS fee schedule amount calculated for the item, less any unmet deductible.

### Medicare Fee Schedule for Clinical Lab Services

Medicare pays clinical lab services according to a separate fee schedule. Medicare pays the lesser of the amount billed, the local fee for a geographic area or a national limit that CMS sets based on the median of all local fee schedule amounts for each laboratory test code.

### Medicare Fee Schedule for Injectable Drugs

Since the Medicare Modernization Act of 2003, Medicare pays for injectable drugs based on a new system called the single drug pricer (SDP), which is the average sales price (ASP) plus six percent (i.e., 106 percent of the ASP). Medicare makes some exceptions to this system for blood clotting factors, some vaccines and end-stage renal disease drugs.

### Commercial Payers

Many commercial payers (e.g., Blue Cross Blue Shield and managed care organizations) use variations of the Medicare relative value units and the RBRVS system to set physician reimbursement or capitation rates. In the 2007 Medicare RBRVS Physicians' Guide, AMA reported that the majority (77 percent) of the commercial health care plans were using a variation of RBRVS.[2] These companies generally adopt the RBRVS methodology by applying a percentage to a range of CPT codes, for example, the fee schedule might be 125 percent of Medicare for Surgery services and 95 percent of Medicare for Evaluation and Management services.

### Other State Medicaid Agencies

State Medicaid agencies use a variety of reimbursement methods to establish fees for physicians and other practitioners' services, including:

- RBRVS-based fees

[2] American Medical Association. (2007). Medicare RBRVS: The Physician's Guide. 136. Chicago: American Medical Association.

- Other relative value unit-based fees
- Usual and customary charges

Although provider costs are an element in some fee schedules, data on physician and other practitioners' costs is not readily available and to our knowledge, no payer has developed a fee schedule based on physician costs.

Given the variation in state Medicaid reimbursement methods and policies, it is often helpful to compare all agencies to a common benchmark like Medicare. A Medicaid-to-Medicare fee index compares the Medicaid fee schedule amount to the Medicare fee schedule amount by CPT code.

*Index value = Medicaid fee schedule / Medicare fee schedule*

Index values can be greater or less than one, and the value gives an indication of the percent of Medicaid fees to Medicare fees. For example, an index value of 1.50 means that the Medicaid fee is 150 percent that of the Medicare fee. Similarly, an index value of .75 means that the Medicaid fee is 75 percent that of the Medicare fee. Some indexes average the values for a selection of codes, or for the entire fee schedule.

A 2004 study of United States Medicaid reimbursement for SFY 2003 found that State Medicaid departments paid, on average, 69 percent of Medicare for all services. For primary care, the percentage of Medicare reimbursement was 62 percent, and for obstetrical care, the percentage of Medicare reimbursement was 84 percent. The Medicaid reimbursement for Colorado exceeded the national average: the State paid 74 percent of Medicare for all services, with 68 percent and 86 percent for primary care and obstetric care, respectively.[3] Table 2 presents the Medicaid to Medicare fee index for Colorado and other states based on state fees schedules used during 2003.

**Table 2: 2003 Medicaid-to-Medicare Fee Index for Selected States[4]**

| State | Overall | Primary Care | Obstetric Care | Other Services |
|---|---|---|---|---|
| United States | .69 | .62 | .84 | .73 |
| Arizona | 1.06 | 1.01 | 1.17 | 1.05 |
| Colorado | .74 | .68 | .86 | .75 |
| Idaho | .92 | .89 | .99 | .93 |

[3] Stephen Zuckerman, Joshua McFeeters, Peter Cunningham and Len Nichols, "Changes In Medicaid Physician Fees, 1998–2003." Health Affairs (June 23, 2004), pp. 374-384.
[4] *Ibid*; Based on Urban Institute data: Health System Change 2003 Medicaid Physician Fee Survey.

### Table 2: 2003 Medicaid-to-Medicare Fee Index for Selected States, Continued

| State | Overall | Primary Care | Obstetric Care | Other Services |
|---|---|---|---|---|
| Nebraska | .95 | .78 | .94 | 1.41 |
| Oklahoma | .72 | .67 | .81 | .73 |
| Wyoming | 1.03 | .96 | 1.07 | 1.12 |

Many states update fee schedules or reimbursement on a regular basis based on budget changes, increases in provider costs or other policy and programmatic factors. The index presented in Table 2 is based on data from 2003, so index values are subject to change. For example, since the data for Table 2 was published, the State of Wyoming increased all fees for Evaluation and Management-related codes to over 100 percent of Medicare.

To provide a more current comparison of Medicaid and Medicare fees, we also obtained more recent fee schedule information from selected states. Appendix A presents the Medicaid-to-Medicare index for Colorado and other states for selected CPT codes that rank high in Colorado by utilization or which were of particular interest to the Task Force. Note that, unlike Table 2, Appendix A does not present the CPT codes by category (i.e., primary care, obstetric care, other services) and this data represents only selected codes, as opposed to the entirety of the fee schedule. While no broad generalizations should therefore be drawn from this analysis, the small sampling of selected codes shown in Appendix A shows the following:

- Four of the five other states that we reviewed – Arizona, Idaho, Nebraska, Oklahoma and Wyoming – use fee schedules that are based on RBRVS.
- For the selected codes, many of the other states had index levels that were within .90 (i.e., Medicaid is 90 percent of Medicare payment) to 1.10 (i.e., Medicaid is 110 percent of Medicare payment).
- Colorado Medicaid payment rates show wide variation for selected codes: the index ranges from .16 for CPT 54150 (circumcision) to 4.93 for 94760 (Noninvasive ear or pulse oximetry).

# SECTION IV: COLORADO PRIMARY CARE PROVIDER RATE TASK FORCE PROCESS

This section describes the composition of the Task Force and provides a synopsis of each Task Force meeting.

## Overview

The Department solicited participation in the Task Force through a February 2007 provider newsletter. From these responses, the Department selected the most representative providers with regard to provider type (e.g., Physician, Nurse Practitioner, etc.) and provider specialty (e.g., Internal Medicine and Anesthesiology). The Department also considered those provider types and specialties that represent the specialties with the highest enrollment in the Colorado Medicaid program (i.e., Pediatrics).

Members of the Task Force and their respective area of practice are listed below:

- Gail Albertson, MD – Internal Medicine
- Mary Beth Bishop – Speech Language Pathology
- Nicki R. Carter, MS, RN, FNP-C – Family Nurse Practitioner
- Randall M. Clark, MD – Anesthesiology
- Laraine Guyette, RN, PhD, CNM – Nurse Midwife
- Karen Leamer, MD – Pediatrics
- Mark Maybury, OD – Optometry
- Don Schiff, MD – Pediatrics
- Aris Sophocles, MD, JD – Family Practice
- Christopher Unrein, DO, FACP, CMD – Internal Medicine/Geriatrics
- Clinton R. White, MD – Internal Medicine
- Barbara Zind, MD – Pediatrics

## Task Force Meetings

All meetings were held in Denver. Some providers outside of the Denver area joined the meetings through conference call. The Department posted public notice of all meetings to inform other stakeholders or interested parties. Staff from the Department attended the meetings, as well. Consultants from Navigant Consulting facilitated the meetings and coordinated discussion among the Task Force and the Department.

Prior to the first Task Force Meeting, Navigant Consulting conducted a series of background analyses to inform the Task Force members about the Colorado Physician fee schedule, Medicare RBRVS fee schedule and the fee schedules used by select Medicaid programs. These analyses were based on an analysis of Colorado Medicaid paid claims data for services rendered during July 1, 2005 to June 30, 2006, as well as research about state and Medicare fee schedules and the consultants' experience.

Based on the discussion at the first Task Force meeting and requests from Task Force members to implement select changes to our analysis (described further below), we conducted additional analyses and reissued this report to the Task Force in advance of the May 30, 2007 meeting. Appendix B presents this analysis and describes our methodology, approach and findings.

In our findings for the Medicaid reimbursement analysis, we identified the following potential shortfalls and disparities:

- There are pronounced differences in fees among the different types of CPT codes. Fees for medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supplies billed with HCPCS (Healthcare Common Procedure Coding System) codes, for example, are 76 percent of Medicare fees, while fees for surgery and radiology codes are 45 percent and 23 percent, respectively, of Medicare fees.

- Evaluation and Management services represent the majority of services with regard to frequency (i.e., number of services) and total payment. Medicaid pays the most for Evaluation and Management codes – 76 percent of Medicare reimbursement.

- Disparities exist within types of Evaluation and Management codes. The fees for the Observation and Critical Care code types, for example, are 50 percent and 58 percent, respectively, of the Medicare fee schedule. Fees for other Evaluation and Management services that are related to newborn care are higher, e.g., fees for newborn care and neonatal critical care are 92 and 89 percent of Medicare fees, respectively.

- Some differences occur on a code-by-code basis. For example, among some preventive visits (90000-series CPT codes[5]), the fees for established visits are generally higher as a percent of Medicare fees than the fees for new visits.

- The Medicare and Medicaid fee schedule differential affects specialties differently. Some providers are paid in aggregate at a higher percent of Medicare fees (Behavioral Health at 71 percent, Pediatrics at 71 percent, Family Practice at 70 percent), while others are paid in aggregate at a lower percentage (Pathology at 38 percent, Surgery at 31 percent, Radiology at 29 percent).

While some of the results presented above are mitigated by recent rate increases (i.e., SFY 2008 rate increases for all anesthesia and surgery services, therapeutic services, immunizations, DME repair and Paraguard contraceptive services as described in Table 1 ), these analyses still demonstrate potential shortfalls and disparities among the Colorado Medicaid physician fee schedule. Many of the disparities are the result of targeted fee increases, as opposed to systematic conversion factor updates or changes. The Department attributes the shortfalls to the constraints of the State budget.

In addition, members of the Task Force noted a concern that some physicians who may have very low Medicaid fees in comparison to Medicare fees do not make a choice in their decisions to participate in the Medicaid program. Hospital-based physicians, such as radiologists, anesthesiologists and pathologists are on staff at hospitals, and provide services to anyone that has been admitted to the hospital. Unlike many of their physician peers, who may choose to not participate in the Medicaid program if fee schedules are viewed as too low, these physicians have no choice in accepting Medicaid patients.

The following sections provide a high level description of the topics covered at each meeting. Because some discussions and analyses were iterative over multiple meetings, note that this discussion does not include copies of the interim materials and analyses mentioned in these summaries. Rather, this paper presents the final versions of information (e.g., the Colorado Medicaid Paid Claims Analysis in Appendix B) in related sections. For more information, see the Table of Contents.

### April 20th, 2007 Meeting

At the first meeting, Task Force members articulated the goals and objectives for the study and discussed the materials and analyses Navigant Consulting had prepared for the Task Force's consideration.

[5] There are, for example, separate CPT codes for preventive visits by age: infant, age 1-4, age 5-11, age 12-17, age 18-39. For each age grouping, there are CPT codes to distinguish a new visit from an established patient visit.

- **Introduction of Task Force Members and Department Staff**
- **Statement of Goals and Objectives** – Every Task Force member was invited to identify issues related to the current Colorado Medicaid fee schedule methodology and fee levels. The Task Force issues are:
  - Medicaid fee schedule rates should promote access to necessary health care services.
  - Medicaid does not always provide incentives for quality health care; Medicaid fees should be increased to levels that encourage providers to provide quality care.
  - Enhancements to the fee schedule are necessary to assure that primary care providers have specialists to whom clients can be referred.
  - The current fee schedule does not have a rational basis and Medicaid should consider other RVU alternatives.
  - Rate adjustments and rate increases should be considered as part of health care reform and a statewide plan.
  - There are disparities in Medicaid fee schedule rates by types of codes within the same series of codes, e.g., well versus sick visits, new vs. established patient visits.
  - Medicaid should consider targeted code increases, for example, for well-patient visits, established patient visits, discharge planning, case management fees and care coordination.
  - There are disparities in coding requirements between Medicaid and standard coding conventions (bundling procedures) which should be eliminated. Where there are discrepancies between Medicaid and Medicare in billing and paying for medical supplies, Medicaid should consider increases for fees related to those codes.
  - There are factors in addition to fee schedule amounts (e.g., billing procedures, bundling policies), that contribute to provider decisions to not participate in the Medicaid program.
  - Medicaid beneficiaries do not always have incentives to cooperate with primary care providers; Medicaid should develop an approach that gives patients an incentive to cooperate with their primary care providers.

- Medicaid beneficiaries sometime access high-cost services such as the emergency room when more appropriate settings (e.g., physicians' offices) are available. Medicaid should develop an approach that includes disincentives for patients to access these high-cost services.

- **Discussion of Fee Schedule Methodology Used by Colorado, Medicare and Other Payers** – In advance of the meeting, the Department distributed an initial report to the Task Force that described and compared the payment methodology used by Colorado Medicaid and other payers. Navigant Consulting also presented more information on the RBRVS payment methodology used by Medicare.

- **Review and Discussion of Colorado Medicaid Paid Claims Analysis** – Navigant Consulting presented the findings from the initial Colorado Medicaid Paid Claims Analysis, which was also included in the preliminary materials that the Department distributed. Task Force members discussed the analysis approach and findings with regard to:

  - ***Benchmarks.*** In our initial analyses, Navigant Consulting compared physician charges to Medicaid fees for many of the analyses. The Task Force discussed this approach and concluded that physician charges were not a satisfactory metric for comparison. The group discussed the benefits and challenges of comparing Colorado Medicaid fees to the fees of another payer, and recommended that we revise our analyses to use geographically-adjusted Medicare fees for Colorado as the benchmark for our paid claims analyses.

  - ***Provider Specialties.*** Task Force members requested that Navigant Consulting collapse the comprehensive list of provider specialties into related categories (e.g., group all cardiac specialties together) for the purposes of analysis (final analysis presented in Appendix B).

  - ***CPT Codes.*** Task Force members requested that Navigant Consulting analyze additional CPT codes in the Medicare to Medicaid Fee Index (final index presented in Appendix A).

### May 30th, 2007 Meeting

At the second meeting, Task Force members reviewed the updated analyses and discussed different payment methodologies in detail. The group also considered an approach for recommending a payment increase to the Colorado Legislature.

- **Review of Issues, Goals and Objectives List** – Navigant Consulting categorized the issues, goals and objectives list from the first meeting into three sections:

- Issues that can be addressed through specific Task Force recommendations
- Issues that are important to the Task Force, but that are outside of the Task Force's responsibilities as defined by House Bill 06-13852
- Issues that are already being addressed by Medicaid and other entities in Colorado (e.g., the Blue Ribbon Commission for Health Care Reform)

The Department distributed this list to the providers in advance. At the second meeting, providers briefly discussed the categorization of items, and reiterated items that were of particular interest to the group.

- **Review of Updated Analyses** – The Department also distributed updated paid claims analyses that addressed the changes requested by the Task Force at the first meeting.

- **Discussion of Medicare as a Benchmark** – The Task Force continued to discuss the benefits and challenges of using Medicare as a benchmark to compare to Colorado Medicaid. In most cases, Medicare fees are significantly higher than Medicaid fees. In using Medicare as a benchmark, however, the Task Force did not want the Colorado Legislature to interpret the Medicare fee as the ideal payment rate. Generally, Medicare fees are below that of commercial payment rates, which were considered more desirable by many members of the Task Force. However, commercial payment fee data is not publicly available. In the absence of alternative data, the group agreed to use Medicare as a benchmark, provided that the Colorado Legislature understood that the Task Force did not consider these fees to be optimal.

- **Discussion of RBRVS** – The Task Force further discussed the RBRVS payment methodology that was presented in the first meeting. The group discussed how this methodology would apply to payments under Colorado Medicaid, and noted that some providers or services can be paid using alternate methodologies (for example, the American Society of Anesthesiologists publishes a Relative Value Guide to use when calculating anesthesiology fees). The Task Force discussed the payment methodology options for physicians, anesthesiology, labs, injectable drugs and new CPT codes. At the end of the meeting, the Task Force agreed to recommend that Colorado Medicaid implement RBRVS for physician services, and also agreed on a methodology for each of the areas noted above.

- **Discussion of Payment Increases** – While the recommendation to implement the RBRVS payment methodology would address many of the instances of rate disparity, it did not fully address the charge related to rate shortfalls. The Task Force discussed payment increases at length, and debated about the percentage increase to recommend to the Colorado Legislature:

- Some Task Force members advocated an increase to make all CPT codes fees 80 percent of Medicare fees. These Task Force members suggested this percentage because it would increase many of the CPT codes to a reasonable level that might be accepted by the Colorado Legislature.

- Other Task Force members preferred to recommend a more substantial increase to 110 percent of Medicare fees. These Task Force members believed that this percentage was closer to that of commercial rates, and to a level that would provide adequate incentives for more Medicaid providers to enroll.

- Some providers suggested targeted increases to a subset of CPT codes, starting with Evaluation and Management codes. These providers acknowledged that increasing all of the codes to 110 percent of Medicare fees, or even a slightly lower percentage of Medicare fees, would require a substantial increase in expenditures, and stated that a targeted increase might require less money and, therefore, be more appealing to the Colorado Legislature.

### June 19th, 2007 Meeting

At the third meeting, Task Force members reviewed expenditure estimates for the options they considered at the second meeting and finalized their recommendations by majority vote.

- **Review of Recommendations To Date** – The Task Force reviewed a summary of their recommendations to date, all of which were related to payment methodology for physician services and other areas.

- **Review of Expenditure Estimates** – In response to the payment increase considerations raised at the second meeting, the Department prepared ad hoc expenditure estimates related to the options. These estimates are not official Department budget estimates. These estimates are intended only for discussion purposes. Any approved budget appropriation could not take place until SFY 2009, at the earliest. All expenditure estimates are reported in SFY 2006 dollars, and have not been inflated forward. Also, this estimate does not account for any changes in service utilization or the number of Medicaid recipients.

  Generally, the expenditure estimates showed that:

  - Increasing codes to 110 percent of Medicare would more than double SFY 2006 fee-for-service expenditures (increase would require approximately 116 percent of the fee-for-service expenditures).

- Increasing only Evaluation and Management codes to 110 percent of Medicare would require approximately a 30 percent increase in fee-for-service expenditures (based on SFY 2006 expenditures).

- Increasing all codes to 85 percent of Medicare would require an approximately 67 percent increase in fee-for-service expenditures (based on SFY 2006 expenditures).

Some Task Force members stated that the expenditure estimates did not include enough modeling or expenditure assumptions to accurately account for the increase. These providers stated, for example, that some of the other Task Force recommendations (e.g., implement a Medical Home Model) might yield potential cost savings that could, in part, offset the full fee-for-service expenditure impact of a higher payment increase. The savings associated with the Medical Home Model or other program changes are not estimated as part of these expenditure projections.

- **Discussed Composition of Task Force** – The Task Force members discussed the composition of the Task Force, and the providers and provider specialties that were not represented in the meetings. As shown in the Colorado Medicaid Paid Claims Analysis in Appendix B, some providers are more affected by the current fee levels than others. The Task Force briefly discussed the implications for these different provider types.

- **Vote of Final Recommendation Related to Rate Increases** – The Task Force continued to discuss the final fee increase to recommend to the Colorado Legislature. There was considerable discussion about whether to recommend a percentage less than 100 percent of Medicare (proposed at 85 percent) as a "first step" to continued fee increases over time based on the fee-for-service expenditure estimates that were presented at the meeting, or to recommend a one-time fee increase. Task Force members also debated whether to develop a recommendation for a fee schedule that is based on a percentage of Medicare. Some Task Force members stated that Medicare rates would not be stable over time, and suggested that the Task Force recommend a fee schedule that would be based on commercial insurance rates with an increase. These members acknowledged that commercial rates are within 110 percent to 140 percent of Medicare fees, an increase that is higher than the highest percentage increase discussed at the second meeting. However, these Task Force members thought that a commercial rate would be more stable over time, and stated that the Task Force should issue a recommendation to the Colorado Legislature that reflected the optimal level of payment. A vote determined that almost one half of the providers supported an interim increase to targeted CPT codes, whereas the majority (slightly more than one half) of providers supported a one-time increase to a level approximating commercial fees.

  More information regarding the final Task Force recommendations is described below in the Task Force Recommendations section.

## SECTION V: TASK FORCE RECOMMENDATIONS

After deliberation and review of the paid claims information, the Task Force developed a series of recommendations to address the fee schedule issues. These recommendations reflect the opinions of the Task Force, and are not necessarily those of the Department. The Task Force recommendations are described below.

***Recommendation 1*: Increase Medicaid fees for physicians and other practitioners to levels that approximate commercial payments.**

The Task Force considered several proposals from members about what percentage increase to the Medicaid fee schedule they should propose. The Task Force initially proposed increases based on the Medicare fee schedule, e.g., 85 percent, 100 percent, 110 percent of Medicare. The group finally chose to recommend a level approximating commercial insurance payments as a benchmark instead of Medicare, because Medicare is subject to political and budgetary constraints that influence payment rates. Commercial rates as a percent of Medicare vary by state, however, Task Force Members stated that commercial payments generally range from 110 percent to 140 percent of Medicare fees. In general, at least half of the payments to physicians come from commercial sources, and physicians consider commercial rates to be adequate to promote access to services. In recommending fees based on commercial insurance fees, the Task Force intended to benchmark Medicaid fees to a payment level that would remain stable over time, yet provide adequate incentives for more providers to enroll with Medicaid.

In the following paragraphs, we present estimates of the fee-for-service expenditures, based on SFY 2006 claims data, for Task Force recommendations. These estimates are not official Department budget estimates. These estimates are intended only for discussion purposes. These estimates relate to fee-for-service expenditures only, and do not include expenditures associated with managed care claims. Any increase to fee-for-service rates could require an increase in the managed care capitation rates. Such increases are not included in these expenditure estimates.

Based on the Department's analysis, Navigant Consulting estimates that Medicaid fee-for-service payments would increase to approximately $275 million if Medicaid increased fees to 110 percent of Medicare. If the commercial insurance rates range as high as 140 percent of Medicare, as reported by some Task Force Members, Navigant Consulting estimates that Medicaid payments would increase as much as approximately $347 million if this option were implemented. This increase is an approximately 171 percent increase from SFY 2006 fee-for-service expenditures of $128 million. A fee-for-service expenditure increase to approximately $347 million represents approximately $174 million in State expenditures, based on the Federal

Medical Assistance Percentages for Colorado for SFY 2007 of .50.[6] We recognize that commercial payments differ by carrier or procedure, so this estimate may overstate total new expenditures (i.e., if the commercial rate is less than 140 percent).

Note that the expenditure estimate presented above is based simply on the difference in SFY 2006 payments and adjusted fees to a new percentage of Medicare. Any approved budget appropriation could not take place until SFY 2009, at the earliest. All expenditure estimates are reported in SFY 2006 dollars, and have not been inflated forward. Also, this estimate does not account for any changes in service utilization or the number of Medicaid recipients. Moreover, this method of approximation does not include any adjustments for changes in patient behavior that might occur under a Medical Home Model or other program changes suggested by the Task Force. The Task Force identified the Medical Home Model as a means of achieving additional cost savings through the more efficient utilization of services and the savings resulting from improved billing processes, in addition to other improvements.

In response to these recommendations, Department representatives suggested that the Task Force might also want to consider how such a significant increase could be implemented incrementally. The Department asked for guidance from Task Force members about how to apply an increase that might be less than the recommended percentage (i.e., a fee-for-service expenditure increase of 5 or 10 percent). The Task Force considered these requests, but ultimately decided to recommend the increase to commercial payment levels because the increase represented the optimal level of reimbursement, and the Task Force wanted the Colorado Legislature to understand the true financial needs of the provider community. The Task Force did not want to suggest to the Colorado Legislature than an increase in fees to levels that would be less than Medicare rates or, moreover, than commercial insurance rates, would be adequate to enroll additional Medicaid providers or retain existing providers to assure access.

### *Recommendation 2*: Implement a physician fee schedule that is based on the Medicare RBRVS methodology.

The Task Force recommended that Colorado Medicaid implement a physician fee schedule that is based on the Medicare RBRVS system. The Task Force made further recommendations about a new fee schedule:

- Consider the entire state of Colorado to be one geographic area, as does Medicare, and make no adjustment for provider location.

[6] Health and Human Services, Federal Medical Assistance Percentages for SFY 2008. Available online: http://aspe.hhs.gov/health/fmap08.htm.

- Determine a single conversion factor for all specialties included in the RBRVS.

- Exclude anesthesiologists from the RBRVS and develop a fee schedule for their services based on the relative values published by the American Society of Anesthesiologists. The Task Force recommended that this conversion factor be calculated to yield an amount that approximates commercial payment levels.

- Pay all providers, including mid-level practitioners, at 100 percent of the fee schedule amount. (Medicare reduces payment for some practitioners, e.g., physician assistants and nurse practitioner/clinical nurse specialists are paid 85 percent of the fee schedule.)

- For any other services that are excluded from the RBRVS, e.g., new procedure codes, purchase a commercial database of relative values, such as the database that is current published by Relative Value Services, Inc.

- Pay for laboratory services, durable medical equipment and drugs that are not self-administered based on the Medicare fee schedule.[7]

## Additional Considerations

Based on these recommendations, we have outlined below a number of further considerations the Department should make as it moves to implement these recommendations to the fee-for-service program:

- **Impact on Managed Care Capitation Rates** – As mentioned above, any increase to fee-for-service rates could require an increase in managed care capitation rates, which further impacts Medicaid expenditures.

- **Implementation Issues** – Moving to an RBRVS with a single conversion factor will likely create "winners" and "losers" among physicians – those who provide more cognitive services (e.g., pediatricians) may receive higher increases than those who perform procedures (e.g., surgeons). Depending upon the level of any appropriated increases to support a fee schedule increase, there is also a potential for some physicians to be paid less than they were previously in the move to the RBRVS system (if, for example, only an incremental increase is given by the Legislature to move the fee schedule toward the intended goal). Some states have mitigated this impact through a phase-in of the RBRVS, whereby the fee schedule is based on a percentage of the old fee schedule (adjusted for any increase) and a percentage of

[7] Colorado Medicaid currently uses the Medicare fee schedule for laboratory services.

RBRVS. Phase-in periods can range from 1 to 3 years. Medicare, for example, phased in the RBRVS by having multiple conversion factors. Some commercial insurers continue to use multiple conversion factors so as not to create the shift in payment from procedures to cognitive services.

- **Update Factor** – The Department will have to determine if it will update the RVUs and conversion factors each year as does Medicare. The RVUs are published by Medicare, and any conversion factor increases would depend on an appropriation from the General Assembly. This requires some administrative time and effort to accomplish, although it is not a complex undertaking. Most states review fee schedules on an annual basis, and make final decisions about how much to update the conversion factor based on state budget.

- **Implementation Costs** – Although the implementation of an RBRVS is not exceedingly complex or time-consuming, the State will incur additional costs through the implementation of the RBRVS. The more closely that Medicaid follows Medicare policies, the easier the implementation. However, Medicare policies are not always compatible with Medicaid policies, and in our experience, States (and commercial payers) frequently diverge from Medicare policies.

- **Separate Payments for Codes that Medicare Bundles** – The Department will have to determine if it will make separate payment for specific codes that Medicare considers to be always bundled into payment for other services not specified.[8] When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.) The RVUs for these other services have been adjusted to account for the bundling of these services.

- **Other Special Policies Regarding Services and Billing** – Medicare RBRVS policy includes a number of policies regarding payment when modifiers are billed. In addition, Medicare has adopted a global surgery billing policy, which requires that a single fee be billed and paid for all necessary services normally furnished by a physician before, during and after a procedure. Medicare defines the global period for surgeries as:

  - The day immediately before the day of surgery (pre-operative period)
  - The day of surgery (intra-operative period)

[8] For Medicare, these are codes with status code B.

- The 90 days immediately following the day of surgery (post-operative period)

For these and other Medicare policies, the Department should consider the potential impact on payments if the Medicare policies are or are not followed.

In addition, with the proposed increase, the Department will have to conduct analyses to assure the Centers for Medicare and Medicaid Services (CMS) that physician payments comply with Federal regulations. Federal regulations require that Medicaid payments be limited to "reasonable charges." According to the *Code of Federal Regulations*, 42 CFR § 405.502:

> *"The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for. The criteria for determining what charges are reasonable include:*
>
> 1. *The customary charges for similar services generally made by the physician or other person furnishing such services.*
> 2. *The prevailing charges in the locality for similar services.*
> 3. *In the case of physicians' services, the prevailing charges adjusted to reflect economic charges adjusted to reflect economic changes …"*

In previous communications with Department staff related to supplemental physician payments, CMS has further clarified that states can use one of three methodologies for determining the amount of their supplemental reimbursement to certain groups of practitioners:

1. Payment up to 100 percent of the Medicare fee schedule rate
2. Payment up to the average commercial rate based on what commercial payers reimburse for services
3. Payment up to the Medicare equivalent of the average commercial rate

The Department has elected to use Option 1 above to determine the upper payment limit for physician services.

## Additional, Broader Task Force Recommendations

The Task Force also made recommendations about issues that affect physician and other practitioner reimbursement, but are greater in scope than the charge to the Task Force. The Task Force discussed these recommendations at length, and the Task Force, Department and Navigant Consulting facilitators determined that these recommendations are outside the scope of the legislative mandate to study rate shortfalls and disparities, but that some of these recommendations are currently being addressed elsewhere, or that they could be addressed to other State entities. These recommendations are:

- Implement incentives for Medicaid patients to seek care and follow healthy behaviors through a Medical Home Model. Medicaid should consider reforms that encourage the Medical Home Model. Task Force members indicated their concern that Medicaid beneficiaries are not always using resources appropriately and that there could potentially be significant savings that could fund physician and other practitioner fee increases if a Medical Home Model were implemented for Colorado Medicaid. Very simply stated, the premise behind the Medical Home Model is that care will be improved if patients have direct access to a medical facility or a physician who accepts responsibility for their care and practices in a system organized to support better care.

- Consider using Medicaid waivers to implement some changes, such as guaranteed eligibility time spans for Medicaid consumers. This would allow providers to provide continuity of care for Medicaid patients.

- Address longer-term system issues that focus on the delivery system as a whole and adopt a comprehensive view that will maximize available dollars.

## SECTION VI: CONCLUSION

The Primary Care Provider Rate Task Force has considered a variety of data and information related to Colorado Medicaid physician and other practitioner reimbursement. The Task Force reviewed and discussed paid claims analyses by individual CPT code, code categories, provider specialties and location. Some Task Force members requested changes to the analyses or additional ad hoc analyses for the group to consider when evaluating payment disparities and shortfalls.

The Department assisted the Task Force in examining issues of rate disparity and rate shortfalls by providing pertinent information regarding historical rate changes, new coding initiates and upcoming rate increases. Department staff were present at every Task Force meeting to answer pointed questions regarding Department policies and practices. In addition, the Task Force reviewed ad hoc expenditure estimates to help them develop final recommendations related to payment increases.

The Task Force has issued both a set of reimbursement-related recommendations and additional, broader recommendations. While the Task Force was divided on some recommendations (i.e., whether to recommend an interim payment increase or a one-step increase to that of commercial rates), all members agreed that an adequate level of reimbursement was key to ensuring continued participation from Colorado Medicaid providers and also incentivizing new providers to enroll.

# APPENDIX A: MEDICAID TO MEDICARE FEE INDEX

Table A-1 presents a Medicaid to Medicare fee index for selected CPT codes. Navigant Consulting selected codes for analysis by examining those codes that ranked high with regard to utilization (i.e., frequency) for Colorado Medicaid, based on our review of paid claims for State Fiscal Year 2006. We also considered codes for which we could gather data for other states. Finally, we included selected CPT codes (e.g., preventive visit series of codes) at the request of Primary Care Rate Task Force (Task Force) members.

We presented this analysis to the Task Force at the first April 20, 2007 meeting. Based on the Task Force member requests, we then updated the analysis for the May 30, 2007 meeting.

**Table A-1 :**
**Medicaid-to-Medicare Fee Index for Selected CPT Codes**

| CPT Code | Description | Medicare Fee Amount[1] | Colorado — Basis: Fee schedule (July 2006) | Arizona — Basis: RBRVS fee schedule (March 2007) | Idaho — Basis: Fee schedule (July 2006) | Nebraska — Basis: RBRVS fee schedule (July 2006) | Oklahoma — Basis: RBRVS fee schedule (July 2006) | Wyoming — Basis: RBRVS fee schedule (October 2006) |
|---|---|---|---|---|---|---|---|---|
| | | | Index | | | | | |
| 17003 | Destroy skin lesions, 2-14 | 10.23 | 1.05 | 1.00 | 1.35 | 0.96 | 0.92 | 1.16 |
| 54150 | Circumcision | 241.03 | 0.16 | —[2] | 1.14 | 0.35 | 0.88 | 1.15 |
| 58300 | Insert intrauterine device | 96.64 | 0.52 | 1.00 | 0.58 | 0.76 | 0.89 | 1.16 |
| 59400 | Antepartum care, vaginal delivery and postpartum care | 1,629.97 | 0.72 | 1.13 | 0.89 | 0.84 | 0.89 | 1.48 |
| 59410 | Postpartum care | 909.16 | 0.85 | 1.23 | 0.91 | 0.94 | 0.90 | 1.68 |
| 59510 | Cesarean delivery and postpartum care | 1,847.12 | 0.76 | 1.13 | 0.89 | 0.93 | 0.89 | 1.66 |
| 59514 | Cesarean delivery only | 959.19 | 0.87 | 1.24 | 0.90 | 1.04 | 0.90 | 1.05 |
| 71020 | Chest x-ray | 36.38 | 0.18 | 1.00 | 0.85 | 1.41 | 0.86 | 0.97 |
| 90935 | Hemodialysis, one evaluation | 73.14 | 2.04 | 1.00 | 1.02 | 2.37 | — | 1.16 |
| 92507 | Speech/hearing therapy | 62.91 | 0.90 | 0.79 | 1.14 | 0.52 | 0.89 | 1.15 |
| 93010 | Electrocardiogram report | 9.10 | 1.17 | 1.00 | 0.97 | 2.29 | 0.94 | 1.16 |
| 94760 | Noninvasive ear or pulse oximetry for oxygen saturation, single | 2.27 | 4.93 | 1.02 | 1.66 | 12.76 | 0.00 | 1.16 |
| 94761 | Noninvasive ear or pulse oximetry for oxygen saturation, multiple | 4.55 | 3.69 | 1.11 | 1.25 | 9.55 | 0.69 | 1.25 |
| 99203 | Office/outpatient visit, new | 97.02 | 0.78 | 1.00 | 0.91 | 0.64 | 0.91 | 1.16 |

[1] Fees adjusted to Colorado geographic practice cost index.
[2] Index values marked with dashes indicate that service was not covered or was restricted by the respective Medicaid fee schedule.

## Table A-1:
## Medicaid-to-Medicare Fee Index for Selected CPT Codes, Continued

| CPT Code | Description | Medicare Fee Amount | Colorado — Basis: Fee schedule (July 2006) | Arizona — Basis: RBRVS fee schedule (March 2007) | Idaho — Basis: Fee schedule (July 2006) | Nebraska — Basis: RBRVS fee schedule (July 2006) | Oklahoma — Basis: RBRVS fee schedule (July 2006) | Wyoming — Basis: RBRVS fee schedule (October 2006) |
|---|---|---|---|---|---|---|---|---|
| | | | Index | | | | | |
| 99212 | Office/outpatient visit | 38.66 | 0.77 | 1.00 | 0.90 | 0.69 | 0.90 | 1.16 |
| 99213 | Office/outpatient visit, expanded | 52.68 | 0.79 | 1.00 | 0.92 | 0.76 | 0.91 | 1.06 |
| 99214 | Office/outpatient visit, detailed | 82.62 | 0.79 | 1.00 | 0.93 | 0.72 | 0.92 | 1.16 |
| 99232 | Subsequent hospital care | 55.71 | 0.75 | 1.00 | 0.95 | 0.78 | 0.95 | 1.16 |
| 99283 | Emergency dept visit, expanded | 61.77 | 0.77 | 1.01 | 0.94 | 0.79 | 0.94 | 1.16 |
| 99284 | Emergency dept visit, detailed | 96.26 | 0.76 | 1.01 | 0.94 | 0.60 | 0.95 | 1.17 |
| 99298 | Intensive care for lbw infant < 1500 gm | 145.15 | 0.69 | 1.01 | 0.94 | .86 | 0.94 | 1.16 |
| 99299 | Intensive care, lbw infant 1500-2500 gm | 132.64 | 0.69 | 1.01 | 0.92 | .55 | 0.94 | 1.16 |
| 99381 | Preventive visit, new, infant | 104.22 | 0.53 | 0.99 | 0.99 | — | 0.91 | 1.15 |
| 99382 | Preventive visit, new, age 1-4 | 112.18 | 0.49 | 0.99 | 1.03 | — | 0.91 | 1.15 |
| 99383 | Preventive visit, new, age 5-11 | 109.90 | 0.50 | 0.99 | 1.04 | — | 0.91 | 1.15 |
| 99384 | Preventive visit, new, age 12-17 | 119.38 | 0.46 | 0.99 | 1.07 | — | 0.91 | 1.15 |
| 99385 | Preventive visit, new, age 18-39 | 119.38 | 0.46 | 0.99 | 1.07 | — | 0.91 | — |
| 99386 | Preventive visit, new, age 40-64 | 140.60 | 0.39 | 0.99 | 0.91 | — | — | — |
| 99387 | Preventive visit, new, 65 & over | 152.35 | 0.36 | 0.99 | 0.84 | — | — | — |
| 99391 | Preventive visit, established, infant | 79.21 | 0.79 | 0.99 | 1.07 | — | 0.91 | 1.15 |
| 99392 | Preventive visit, established, age 1-4 | 88.68 | 0.80 | 0.99 | 1.10 | — | 0.91 | 1.15 |
| 99393 | Preventive visit, established, age 5-11 | 87.16 | 0.46 | 1.00 | 1.12 | — | 0.92 | 1.03 |
| 99394 | Preventive visit, established, age 12-17 | 96.64 | 0.42 | 0.99 | 1.14 | — | 0.92 | 1.03 |
| 99395 | Preventive visit, established, age 18-39 | 97.78 | 0.41 | 0.99 | 1.13 | — | 0.92 | — |
| 99396 | Preventive visit, established, age 40-64 | 108.01 | 0.37 | 0.99 | 1.03 | — | — | — |
| 99397 | Preventive visit, established, 65 & over | 119.00 | 0.34 | 0.99 | 0.93 | — | — | — |
| 99436 | Attendance, birth | 76.55 | 1.05 | 1.01 | 0.96 | 1.21 | 0.95 | 1.16 |

# APPENDIX B: COLORADO MEDICAID PAID CLAIMS ANALYSIS

Appendix B presents the findings from our review of Colorado Medicaid paid claims. We presented this analysis to the Task Force in advance of the first April 20, 2007 meeting. Based on the discussion at the first Task Force meeting and requests from Task Force members to implement select changes to our analysis (e.g., compare paid claims to Medicare instead of physician charges), we updated our analyses and re-issued this report to the Task Force in advance of the May 30, 2007 meeting.

## Introduction to the Paid Claims Analysis

To assess provider payment levels under the current fee schedule, we analyzed the claims paid by the Department to Medicaid providers for services rendered during July 1, 2005 to June 30, 2006. We excluded claims related to those recipients who are dually eligible for Medicaid and Medicare (also called Medicare crossover claims).

We studied claims with CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes. Similar to CPT codes, providers use HCPCS codes for billing. HCPCS codes identify medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supplies. We adjusted all claims to account for any Colorado Medicaid or provider adjustments to billed units, charges or reimbursements. We then conducted our analysis without regard to the co-payments or other third-party liability associated with claims.

## Colorado Medicare Data

The analysis of the Task Force focused primarily on the comparison of the Medicaid fee schedule to the Medicare fee schedule.[1] The Task Force agreed that provider charges are not a meaningful measure, because providers are free to determine their own charges and there is such variability in charges with no explanation as to why that variability exists. Some Task Force members suggested that provider "costs" be determined and used for a benchmark, however, they concurred that such data is currently not available and would be difficult to collect in any timely manner.

To conduct the comparisons of Medicare and Medicaid fees, we compared Colorado Medicaid claims with the Medicare physician fee schedule after adjusting for:

- Medicare geographic practice cost index for Colorado — To adjust the Medicare RBRVS fee schedule for the regional variation in Medicare reimbursement. For Colorado, the

[1] Analyses compare the allowed charge amount (i.e., the fee schedule) paid by Colorado Medicaid to the allowed charge amount paid by Medicare (i.e., the geographically adjusted Medicare fee).

Medicare geographic practice cost index for 2006 was 1.00 for the Work component, 1.014 for the Practice component and .803 for the Malpractice component.

- 2006 RBRVS conversion factor — To convert the Medicare fees to Federal Fiscal Year 2006 payment levels. For Federal Fiscal Year 2006, the RBRVS conversion factor was 37.8975.
- Changes in American Medical Association CPT codes — To account for those CPT codes that were changed or updated in the 2006 fee schedule.

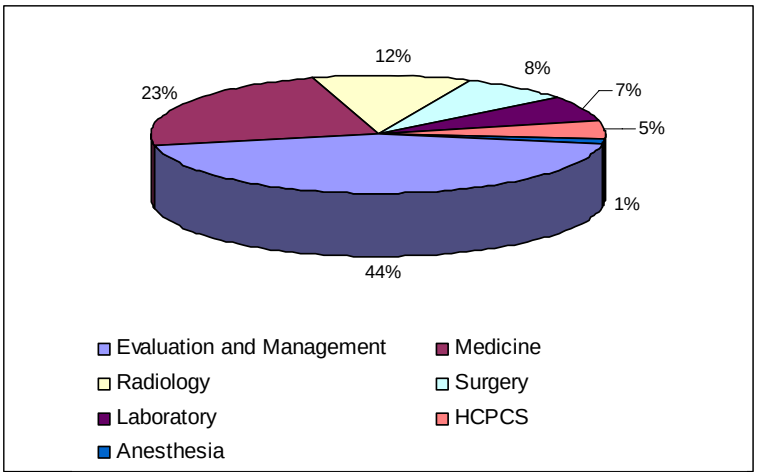
## Analyses

We considered the claims data with regard to CPT and HCPCS codes, provider type, provider specialty and geographic area. The sections that follow present the results of these analyses and key findings.

**FINDING #1: Evaluation and Management codes represent the major category of CPT codes by frequency and by overall reimbursement. CPT codes for Surgery represent a small percent of all codes by frequency, but almost one-fourth of all reimbursement. Conversely, Radiology represents a larger percentage of all codes by frequency, but a smaller percentage of codes by reimbursement.**

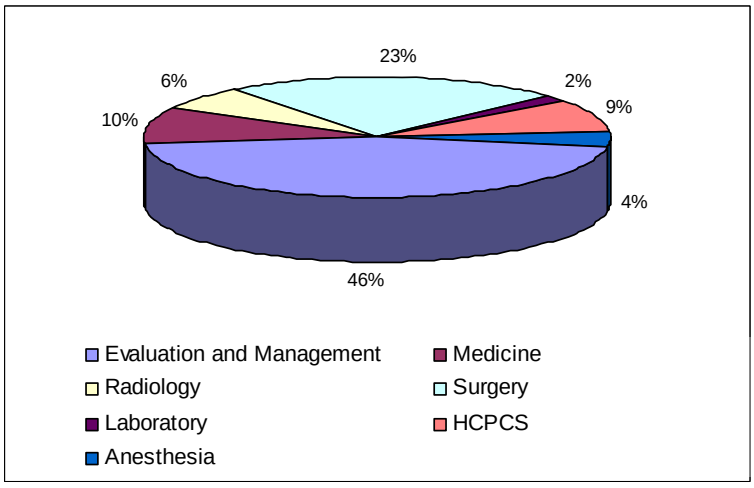
### Exhibit B-1:
### Frequency of CPT Codes by Category[2]

***Evaluation and Management*** CPT codes represent the majority — 44 percent — of all billed services. ***Medicine*** (23 percent) and ***Radiology*** (12 percent) represent the second and third most commonly billed services, respectively.




### Exhibit B-2:
### Reimbursement of CPT Codes by Category[3]

The Department spends 46 percent of all physician and other practitioner reimbursement on ***Evaluation and Management*** services. The Department spends 23 percent of reimbursement on ***Surgery*** services, 10 percent on ***Medicine*** and 9 percent on ***HCPCS*** services.




[2] Anesthesia claims represent those anesthesia services that are billed on a CPT code basis. Other anesthesia services that are associated with hospital claims are not included in this analysis.
[3] *Ibid.*

**FINDING #2: HCPCS codes and Evaluation and Management codes were reimbursed the highest percent of Medicare fees (76 percent and 74 percent, respectively). Laboratory and Radiology were reimbursed the lowest percentage of Medicare fees (38 percent and 23 percent, respectively).**

### Exhibit B-3: Medicaid Fees as a Percent of Medicare Fees by CPT Category[4]

| CPT Category | Medicaid Fees as a Percent of Medicare[5] |
|---|---|
| HCPCS | 76% |
| Evaluation and Management | 74% |
| Medicine | 52% |
| Surgery | 45% |
| Laboratory | 38% |
| Radiology | 23% |

[4] Analysis excludes anesthesia codes because of the different payment methodology used by Medicare.
[5] Analyses do not reflect SFY payment increases to anesthesia, surgery and therapeutic services.

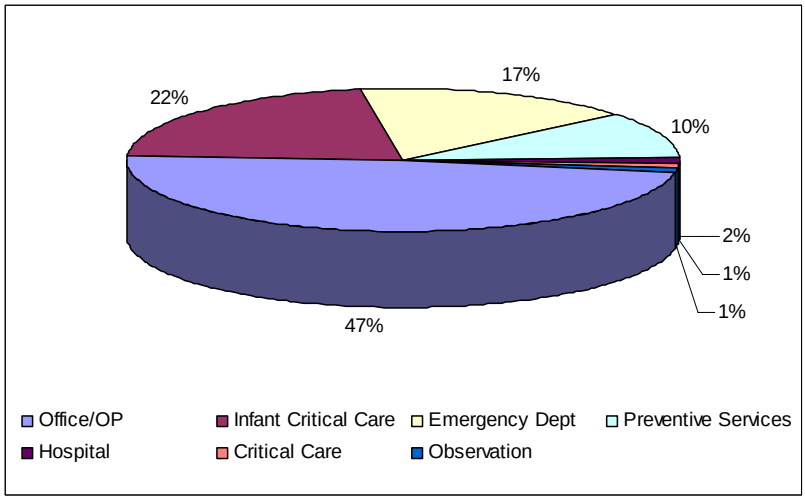
**FINDING #3: Outpatient Office Visit codes accounted for nearly half of all Evaluation and Management codes, but a smaller comparative proportion of total reimbursement. Codes related to Infant Critical Care services had a greater proportion of reimbursement than frequency.**

### Exhibit B-4: Frequency of Evaluation and Management Codes

***Outpatient Office*** (48 percent) codes are the majority of Evaluation and Management codes. ***Emergency Department*** (17 percent) and ***Preventive Services*** (10 percent) were the second largest code categories.

Top Outpatient Office codes include:

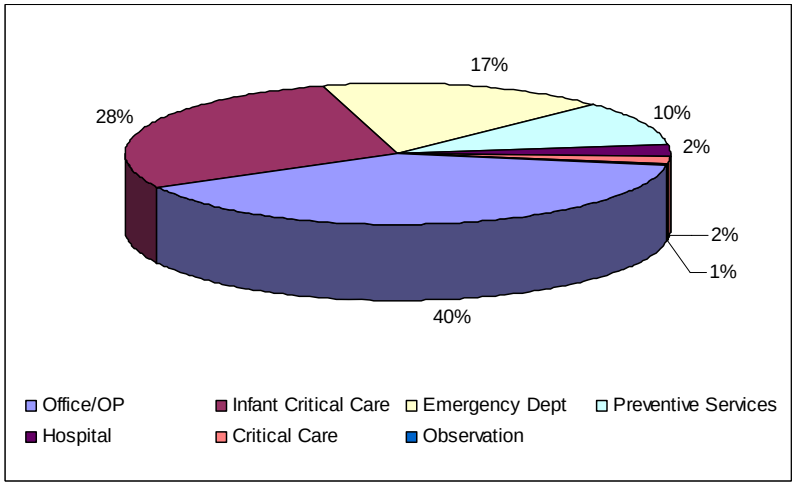
- Office/outpatient visit, new: 99204, 99203, 99201, 99205, 99202
- Office/outpatient visit, established: 99215, 99214, 99213, 99212, 99211




**Note**: *Infant Critical Care* includes Neonatal Critical Care, Pediatric Critical Care and Low Birth Weight Infant and Observation.

### Exhibit B-5: Reimbursement of Evaluation and Management Codes

The Department spends 40 percent of all Evaluation and Management reimbursement for ***Office/Outpatient*** services. ***Infant Critical Care*** and ***Emergency Department*** services represent 28 percent and 17 percent, respectively.



**FINDING #4: Within Evaluation and Management codes, Newborn Care and Neonatal Critical Care were reimbursed at the highest percent of Medicare fees. Preventive Services, Critical Care and Observation were reimbursed at the lowest percent of Medicare.**

**Exhibit B-6: Medicaid Fees as a Percent of Medicare Fees by Type of Evaluation and Management CPT Service**

| Evaluation and Management Type | Medicaid Fees as a Percent of Medicare |
|---|---|
| Newborn Care | 92% |
| Neonate Critical Care | 89% |
| Emergency Department | 77% |
| Office/Outpatient | 76% |
| Hospital | 74% |
| Other (Subsequent Hospital Care) | 71% |
| Low Birth Weight Infant | 69% |
| Pediatric Critical Care | 67% |
| Preventive Services | 66% |
| Critical Care | 58% |
| Observation | 50% |

## FINDING #5: There is significant variation in Colorado Medicaid fees in comparison to Colorado Medicare fees; there is also variation in fees in comparison to Colorado Medicare within the same type of services.

We analyzed frequently occurring Medicaid CPT codes and compared the Medicaid fees to the Colorado Medicare fees. Exhibit 7 presents Medicaid fees as a percent of Medicare fees for the top 200 CPT codes for Colorado.

### Exhibit B-7:
### Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 99213 | Office/outpatient visit, est | 296,136 | 41.75 | 52.68 | 79% |
| 99214 | Office/outpatient visit, est | 98,763 | 65.18 | 82.62 | 79% |
| 99283 | Emergency dept visit | 91,619 | 47.74 | 61.77 | 77% |
| 99284 | Emergency dept visit | 60,216 | 73.02 | 96.26 | 76% |
| 99212 | Office/outpatient visit, est | 55,812 | 29.93 | 38.66 | 77% |
| 99391 | Prev visit, est, infant | 51,951 | 62.97 | 79.21 | 79% |
| 99232 | Subsequent hospital care | 46,214 | 41.83 | 55.71 | 75% |
| 36415 | Routine venipuncture | 39,477 | 3.00 | n/a | n/a |
| 92507 | Speech/hearing therapy | 37,930 | 56.70 | 62.91 | 90% |
| 90669 | Pneumococcal vacc, ped <5 | 37,620 | 6.50 | n/a | n/a |
| 71020 | Chest x-ray | 37,011 | 6.72 | 36.38 | 18% |
| 90700 | Dtap vaccine, < 7 yrs, im | 29,439 | 6.50 | n/a | n/a |
| 94760 | Measure blood oxygen level | 29,150 | 11.20 | 2.27 | 493% |
| 99392 | Prev visit, est, age 1-4 | 28,807 | 70.53 | 88.68 | 80% |
| 99233 | Subsequent hospital care | 28,433 | 58.27 | 79.21 | 74% |
| 99203 | Office/outpatient visit, new | 26,935 | 75.96 | 97.02 | 78% |
| 71010 | Chest x-ray | 26,250 | 4.03 | 28.04 | 14% |
| 97532 | Cognitive skills development | 25,835 | 19.74 | 24.63 | 80% |
| 99000 | Specimen handling | 23,608 | 3.00 | n/a | n/a |
| 90713 | Poliovirus, ipv, sc/im | 23,090 | 6.50 | n/a | n/a |
| 99238 | Hospital discharge day | 22,539 | 49.39 | 70.87 | 70% |
| 92340 | Fitting of spectacles | 22,400 | 16.80 | 41.31 | 41% |
| 97112 | Neuromuscular reeducation | 21,294 | 10.50 | 29.18 | 36% |

## Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 99285 | Emergency dept visit | 20,269 | 115.14 | 150.45 | 77% |
| 99211 | Office/outpatient visit, est | 19,904 | 12.18 | 21.60 | 56% |
| 93010 | Electrocardiogram report | 19,378 | 10.64 | 9.10 | 117% |
| 99204 | Office/outpatient visit, new | 18,178 | 107.41 | 137.19 | 78% |
| 99282 | Emergency dept visit | 16,665 | 26.07 | 27.29 | 96% |
| 90723 | Dtap-hep b-ipv vaccine, im | 15,330 | 6.50 | n/a | n/a |
| 90707 | Mmr vaccine, sc | 14,786 | 6.50 | n/a | n/a |
| 99231 | Subsequent hospital care | 14,665 | 28.28 | 34.11 | 83% |
| 97533 | Sensory integration | 14,433 | 41.66 | 26.15 | 159% |
| 99215 | Office/outpatient visit, est | 13,866 | 94.53 | 120.14 | 79% |
| 90658 | Flu vaccine age 3 & over, im | 13,688 | 6.50 | n/a | n/a |
| 99431 | Initial care, normal newborn | 13,463 | 57.06 | 60.64 | 94% |
| 90633 | Hep a vacc, ped/adol, 2 dose | 13,437 | 6.50 | n/a | n/a |
| 97110 | Therapeutic exercises | 13,433 | 10.50 | 28.04 | 37% |
| 99243 | Office consultation | 11,780 | 75.46 | 122.41 | 62% |
| 99299 | Ic, lbw infant 1500-2500 gm | 11,772 | 91.28 | 132.64 | 69% |
| 99202 | Office/outpatient visit, new | 11,590 | 43.26 | 65.18 | 66% |
| 90657 | Flu vaccine, 6-35 mo, im | 11,529 | 6.50 | n/a | n/a |
| 59025 | Fetal non-stress test | 11,429 | 34.10 | 41.69 | 82% |
| 99393 | Prev visit, est, age 5-11 | 10,981 | 40.15 | 87.16 | 46% |
| 70450 | Ct head/brain w/o dye | 10,968 | 36.29 | 233.45 | 16% |
| 99244 | Office consultation | 10,731 | 135.21 | 172.81 | 78% |
| 76805 | Ob us >/= 14 wks, sngl fetus | 10,335 | 38.64 | 136.43 | 28% |
| 90645 | Hib vaccine, hboc, im | 10,313 | 6.50 | n/a | n/a |
| 92004 | Eye exam, new patient | 9,396 | 28.59 | 129.99 | 22% |
| 90748 | Hep b/hib vaccine, im | 9,383 | 6.50 | n/a | n/a |
| 99223 | Initial hospital care | 8,888 | 113.29 | 156.90 | 72% |
| 99433 | Normal newborn care/hospital | 8,814 | 35.50 | 31.83 | 112% |
| 90716 | Chicken pox vaccine, sc | 8,622 | 6.50 | n/a | n/a |
| 36416 | Capillary blood draw | 8,173 | 3.00 | n/a | n/a |
| 97535 | Self care mngment training | 7,779 | 15.76 | 29.94 | 53% |
| 90648 | Hib vaccine, prp-t, im | 7,759 | 6.50 | n/a | n/a |
| 76815 | Ob us, limited, fetus(s) | 7,539 | 23.18 | 91.33 | 25% |
| 93325 | Doppler color flow add-on | 7,529 | 37.52 | 122.41 | 31% |
| 59400 | Obstetrical care | 7,214 | 1168.38 | 1629.97 | 72% |

## Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 76811 | Ob us, detailed, sngl fetus | 6,716 | 69.35 | 251.26 | 28% |
| 93320 | Doppler echo exam, heart | 6,710 | 62.44 | 89.82 | 70% |
| 99291 | Critical care, first hour | 6,617 | 149.32 | 256.57 | 58% |
| 76817 | Transvaginal us, obstetric | 6,602 | 26.81 | 99.67 | 27% |
| 99381 | Prev visit, new, infant | 6,406 | 55.05 | 104.22 | 53% |
| 90647 | Hib vaccine, prp-omp, im | 6,339 | 6.50 | n/a | n/a |
| 72193 | Ct pelvis w/dye | 6,338 | 58.46 | 334.63 | 17% |
| 99222 | Initial hospital care | 6,326 | 88.37 | 112.56 | 79% |
| 74160 | Ct abdomen w/dye | 6,190 | 67.20 | 340.70 | 20% |
| 99394 | Prev visit, est, age 12-17 | 6,148 | 40.15 | 96.64 | 42% |
| 92014 | Eye exam & treatment | 6,110 | 28.00 | 96.64 | 29% |
| 97140 | Manual therapy | 5,983 | 12.60 | 26.15 | 48% |
| 74000 | X-ray exam of abdomen | 5,864 | 4.03 | 29.94 | 13% |
| 76830 | Transvaginal us, non-ob | 5,836 | 33.60 | 97.40 | 34% |
| 76816 | Ob us, follow-up, per fetus | 5,517 | 52.28 | 90.20 | 58% |
| 59409 | Obstetrical care | 5,503 | 708.72 | 812.90 | 87% |
| 99242 | Office consultation | 5,484 | 58.16 | 91.71 | 63% |
| 92526 | Oral function therapy | 5,430 | 23.10 | 84.51 | 27% |
| 94640 | Airway inhalation treatment | 5,406 | 12.60 | 12.13 | 104% |
| 99239 | Hospital discharge day | 5,391 | 67.56 | 96.64 | 70% |
| 73630 | X-ray exam of foot | 5,255 | 3.36 | 29.94 | 11% |
| 99296 | Neonate critical care subseq | 5,250 | 428.01 | 410.43 | 104% |
| 73610 | X-ray exam of ankle | 5,045 | 4.03 | 29.94 | 13% |
| 92567 | Tympanometry | 4,898 | 8.68 | 21.98 | 39% |
| 54150 | Circumcision | 4,866 | 38.11 | 241.03 | 16% |
| 90744 | Hepb vacc ped/adol 3 dose im | 4,840 | 6.50 | n/a | n/a |
| 97530 | Therapeutic activities | 4,628 | 21.00 | 29.18 | 72% |
| 99294 | Ped critical care, subseq | 4,533 | 275.60 | 409.29 | 67% |
| 76801 | Ob us < 14 wks, single fetus | 4,368 | 35.41 | 136.43 | 26% |
| 11721 | Debride nail, 6 or more | 4,351 | 32.09 | 39.41 | 81% |
| 59514 | Cesarean delivery only | 4,214 | 166.15 | 959.19 | 17% |
| 73130 | X-ray exam of hand | 4,185 | 3.36 | 29.94 | 11% |
| 99173 | Visual acuity screen | 4,182 | 10.08 | n/a | n/a |
| 99309 | Nursing fac care, subseq | 4,119 | 46.73 | 79.58 | 59% |
| 99205 | Office/outpatient visit, new | 4,112 | 124.54 | 174.33 | 71% |
| 99245 | Office consultation | 4,096 | 142.69 | 223.60 | 64% |

## Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 73110 | X-ray exam of wrist | 4,053 | 4.03 | 29.94 | 13% |
| 99201 | Office/outpatient visit, new | 3,965 | 24.78 | 36.76 | 67% |
| 99254 | Initial inpatient consult | 3,791 | 106.65 | 141.74 | 75% |
| 99395 | Prev visit, est, age 18-39 | 3,646 | 40.15 | 97.78 | 41% |
| 93307 | Echo exam of heart | 3,558 | 49.00 | 205.03 | 24% |
| 99354 | Prolonged service, office | 3,440 | 43.09 | 99.29 | 43% |
| 76705 | Echo exam of abdomen | 3,426 | 20.90 | 87.54 | 24% |
| 93000 | Electrocardiogram, complete | 3,420 | 21.28 | 26.91 | 79% |
| 74150 | Ct abdomen w/o dye | 3,383 | 43.68 | 289.16 | 15% |
| 95117 | Immunotherapy injections | 3,237 | 12.35 | 19.71 | 63% |
| 72192 | Ct pelvis w/o dye | 3,151 | 36.29 | 294.08 | 12% |
| 76856 | Us exam, pelvic, complete | 3,079 | 35.62 | 97.40 | 37% |
| 93303 | Echo transthoracic | 3,078 | 60.84 | 224.73 | 27% |
| 99308 | Nursing fac care, subseq | 3,016 | 38.22 | 56.47 | 68% |
| 76818 | Fetal biophys profile w/nst | 2,978 | 30.24 | 121.27 | 25% |
| 99382 | Prev visit, new, age 1-4 | 2,968 | 55.05 | 112.18 | 49% |
| 73090 | X-ray exam of forearm | 2,928 | 4.03 | 28.80 | 14% |
| 99298 | Ic for lbw infant < 1500 gm | 2,878 | 100.66 | 145.15 | 69% |
| 72100 | X-ray exam of lower spine | 2,869 | 8.06 | 38.28 | 21% |
| 99253 | Initial inpatient consult | 2,844 | 77.56 | 98.53 | 79% |
| 94010 | Breathing capacity test | 2,827 | 30.80 | 32.97 | 93% |
| 71260 | Ct thorax w/dye | 2,816 | 58.46 | 347.90 | 17% |
| 76700 | Us exam, abdom, complete | 2,793 | 35.62 | 121.65 | 29% |
| 74022 | X-ray exam series, abdomen | 2,726 | 9.41 | 45.86 | 21% |
| 76092 | Mammogram, screening | 2,673 | 13.44 | 85.65 | 16% |
| 73140 | X-ray exam of finger(s) | 2,640 | 3.36 | 23.50 | 14% |
| 76770 | Us exam abdo back wall, comp | 2,597 | 35.62 | 117.48 | 30% |
| 99383 | Prev visit, new, age 5-11 | 2,586 | 55.05 | 109.90 | 50% |
| 73590 | X-ray exam of lower leg | 2,509 | 5.38 | 29.56 | 18% |
| 73562 | X-ray exam of knee, 3 | 2,506 | 5.38 | 32.59 | 17% |
| 73030 | X-ray exam of shoulder | 2,456 | 5.38 | 32.59 | 17% |
| 69436 | Create eardrum opening | 2,449 | 133.72 | 168.26 | 79% |
| 72170 | X-ray exam of pelvis | 2,415 | 6.72 | 29.56 | 23% |
| 69210 | Remove impacted ear wax | 2,377 | 20.06 | 48.89 | 41% |
| 92065 | Orthoptic/pleoptic training | 2,363 | 28.00 | 34.87 | 80% |
| 99384 | Prev visit, new, age 12-17 | 2,283 | 55.05 | 119.38 | 46% |

## Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 99255 | Initial inpatient consult | 2,282 | 144.68 | 195.17 | 74% |
| 20610 | Drain/inject, joint/bursa | 2,266 | 48.81 | 69.73 | 70% |
| 58300 | Insert intrauterine device | 2,239 | 50.15 | 96.64 | 52% |
| 12001 | Repair superficial wound(s) | 2,219 | 33.43 | 145.53 | 23% |
| 70553 | Mri brain w/o & w/dye | 2,194 | 83.06 | 1121.01 | 7% |
| 17000 | Destroy benign/premlg lesion | 2,060 | 46.13 | 61.02 | 76% |
| 12011 | Repair superficial wound(s) | 2,033 | 40.12 | 153.86 | 26% |
| 73080 | X-ray exam of elbow | 1,981 | 4.03 | 32.21 | 13% |
| 59410 | Obstetrical care | 1,972 | 773.57 | 909.16 | 85% |
| 92551 | Pure tone hearing test, air | 1,942 | 10.64 | n/a | n/a |
| 99221 | Initial hospital care | 1,937 | 54.35 | 67.84 | 80% |
| 93971 | Extremity study | 1,922 | 15.51 | 23.88 | 65% |
| 99217 | Observation care discharge | 1,916 | 37.49 | 70.87 | 53% |
| 95115 | Immunotherapy, one injection | 1,871 | 8.93 | 15.54 | 57% |
| 90718 | Td vaccine > 7, im | 1,860 | 6.50 | n/a | n/a |
| 72040 | X-ray exam of neck spine | 1,835 | 6.72 | 35.62 | 19% |
| 64450 | N block, other peripheral | 1,810 | 16.72 | 99.67 | 17% |
| 59510 | Cesarean delivery | 1,804 | 1402.39 | 1847.12 | 76% |
| 99219 | Observation care | 1,778 | 79.24 | 111.80 | 71% |
| 73560 | X-ray exam of knee, 1 or 2 | 1,760 | 4.03 | 29.56 | 14% |
| 92506 | Speech/hearing evaluation | 1,754 | 30.88 | 133.40 | 23% |
| 43235 | Uppr gi endoscopy, diagnosis | 1,726 | 140.41 | 295.60 | 48% |
| 97035 | Ultrasound therapy | 1,719 | 8.40 | 12.13 | 69% |
| 99310 | Nursing fac care, subseq | 1,691 | 60.73 | 99.67 | 61% |
| 99300 | Ic, infant pbw 2501-5000 gm | 1,690 | 133.03 | 127.71 | 104% |
| 72148 | Mri lumbar spine w/o dye | 1,659 | 67.87 | 576.04 | 12% |
| 99436 | Attendance, birth | 1,618 | 80.58 | 76.55 | 105% |
| 73510 | X-ray exam of hip | 1,541 | 6.72 | 34.11 | 20% |
| 73564 | X-ray exam, knee, 4 or more | 1,538 | 5.38 | 36.38 | 15% |
| 94761 | Measure blood oxygen level | 1,514 | 16.80 | 4.55 | 369% |
| 90715 | Tdap vaccine >7 im | 1,502 | 6.50 | n/a | n/a |
| 70551 | Mri brain w/o dye | 1,501 | 84.00 | 526.40 | 16% |
| 73550 | X-ray exam of thigh | 1,481 | 5.38 | 32.21 | 17% |
| 57454 | Bx/curett of cervix w/scope | 1,473 | 105.30 | 159.93 | 66% |
| 74020 | X-ray exam of abdomen | 1,468 | 9.41 | 39.03 | 24% |
| 73620 | X-ray exam of foot | 1,432 | 2.69 | 27.67 | 10% |

## Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

| CPT Code | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 92552 | Pure tone audiometry, air | 1,413 | 10.64 | 18.19 | 58% |
| 70486 | Ct maxillofacial w/o dye | 1,403 | 36.29 | 248.23 | 15% |
| 76819 | Fetal biophys profil w/o nst | 1,367 | 24.06 | 105.73 | 23% |
| 95819 | Eeg, awake and asleep | 1,364 | 26.07 | 60.26 | 43% |
| 72125 | Ct neck spine w/o dye | 1,363 | 36.29 | 297.50 | 12% |
| 76645 | Us exam, breast(s) | 1,363 | 40.32 | 70.11 | 58% |
| 90935 | Hemodialysis, one evaluation | 1,359 | 149.52 | 73.14 | 204% |
| 90818 | Psytx, hosp, 45-50 min | 1,355 | 60.64 | 99.29 | 61% |
| 99435 | Newborn discharge day hosp | 1,335 | 80.75 | 81.48 | 99% |
| 95004 | Percut allergy skin tests | 1,331 | 183.68 | 4.17 | 4405% |
| 43239 | Upper GI endoscopy, biopsy | 1,314 | 20.06 | 335.77 | 6% |
| 97001 | Pt evaluation | 1,309 | 33.60 | 75.80 | 44% |
| 59426 | Antepartum care only | 1,300 | 403.83 | 663.96 | 61% |
| 99295 | Neonate crit care, initial | 1,294 | 511.00 | 942.13 | 54% |
| 99218 | Observation care | 1,283 | 19.60 | 67.08 | 29% |
| 92012 | Eye exam established pat | 1,282 | 19.60 | 65.56 | 30% |
| 62270 | Spinal fluid tap, diagnostic | 1,273 | 33.43 | 160.69 | 21% |
| 73070 | X-ray exam of elbow | 1,264 | 3.36 | 28.42 | 12% |
| 73721 | Mri jnt of lwr extre w/o dye | 1,247 | 47.71 | 513.13 | 9% |
| 72050 | X-ray exam of neck spine | 1,245 | 13.44 | 51.92 | 26% |
| 73100 | X-ray exam of wrist | 1,244 | 2.69 | 27.67 | 10% |
| 71275 | Ct angiography, chest | 1,240 | 46.23 | 588.93 | 8% |
| 76083 | Computer mammogram add-on | 1,227 | 2.15 | 19.71 | 11% |
| 99281 | Emergency dept visit | 1,220 | 16.91 | 16.67 | 101% |
| 99252 | Initial inpatient consult | 1,216 | 58.69 | 72.01 | 82% |
| 92557 | Comprehensive hearing test | 1,207 | 28.00 | 49.27 | 57% |
| 99234 | Observ/hosp same date | 1,185 | 83.10 | 135.29 | 61% |
| 99241 | Office consultation | 1,184 | 36.99 | 50.40 | 73% |
| 90734 | Meningococcal vaccine, im | 1,149 | 6.50 | n/a | n/a |
| 59425 | Antepartum care only | 1,141 | 234.68 | 378.22 | 62% |
| 76506 | Echo exam of head | 1,138 | 40.32 | 92.09 | 44% |
| 90655 | Flu vaccine no preserv 6-35m | 1,133 | 6.50 | n/a | n/a |
| 17003 | Destroy lesions, 2-14 | 1,127 | 10.70 | 10.23 | 105% |
| 99220 | Observation care | 1,127 | 58.80 | 157.27 | 37% |

We also compared Medicaid fees as a percent of Medicare fees for selected codes identified by the Task Force as important. These are fees for codes that fall within the same type of CPT; the Task Force wanted to be able to compare new patient visits with established patient visits. Exhibit 8 provides a comparison of the Colorado Medicaid allowed amount to the Medicare allowed amount adjusted for Colorado for infants and children for new and established patient visits.

## Exhibit B-8:
## Selected CPT Codes: Medicaid Fees as a Percent of Medicare Fees

| CPT Code[6] | CPT Description | Line Items | Medicaid Fee Schedule Allowed Amount | Colorado-specific Medicare Fee Schedule Allowed Amount | Medicaid Fee as a Percent of Colorado-specific Medicare Fee |
|---|---|---|---|---|---|
| 99381 | Prev visit, new, infant | 6,406 | 55.05 | 104.22 | 53% |
| 99382 | Prev visit, new, age 1-4 | 2,968 | 55.05 | 112.18 | 49% |
| 99383 | Prev visit, new, age 5-11 | 2,586 | 55.05 | 109.90 | 50% |
| 99384 | Prev visit, new, age 12-17 | 2,283 | 55.05 | 119.38 | 46% |
| 99385 | Prev visit, new, age 18-39 | 745 | 55.05 | 119.38 | 46% |
| 99386 | Prev visit, new, age 40-64 | 172 | 55.05 | 140.60 | 39% |
| 99387 | Prev visit, new, 65 & over | 28 | 55.05 | 152.35 | 36% |
| 99391 | Prev visit, est, infant | 51,951 | 62.97 | 79.21 | 80% |
| 99392 | Prev visit, est, age 1-4 | 28,807 | 70.53 | 88.68 | 80% |
| 99393 | Prev visit, est, age 5-11 | 10,981 | 40.15 | 87.16 | 46% |
| 99394 | Prev visit, est, age 12-17 | 6,148 | 40.15 | 96.64 | 42% |
| 99395 | Prev visit, est, age 18-39 | 3,646 | 40.15 | 97.78 | 41% |
| 99396 | Prev visit, est, age 40-64 | 941 | 40.15 | 108.01 | 37% |
| 99397 | Prev visit, est, 65 & over | 59 | 40.15 | 119.00 | 34% |

[6] CPT codes and descriptions are a copyright of the American Medical Association, 2006.

# FINDING #6: Medicaid fees as a percent of Medicare fees also vary by specialty.

We also compared Medicaid fees as a percent of Medicare fees by specialty. Exhibit 9 groups 61 provider specialties into 13 categories and shows, for each category, Medicaid fees as a percent of Medicare fees.

**Exhibit B-9:**
**Medicaid Fees as a Percent of Medicare Fees[7] for Categories of Provider Specialties[8,9]**

| Provider Category | Provider Specialties | Percent of Line Items[10] | Medicaid Fees as a Percent of Colorado-specific Medicare Fees[11] |
|---|---|---|---|
| Behavioral Health | Child Psychiatry<br>Neuropsychology<br>Psychiatry | >1% | 71% |
| Pediatrics | Children's Hearing Aid Program<br>Health Care Program for Special Needs Children<br>Neonatologist<br>Pediatrics | 17% | 71% |
| Family Practice | Family Practice | 14% | 70% |
| Non-physician practitioner | Pediatric Nurse Practitioner<br>Nurse Practitioner OB/GYN (Midwife)<br>Indirect Pay (Incident to a Physician)<br>Direct Pay (Not Incident to a Physician) | 11% | 64% |
| OB/GYN | Gynecology<br>Obstetrics<br>Obstetrics and Gynecology<br>Perinatology | 5% | 61% |
| Other Specialty | Hematology<br>Neoplastic Diseases<br>Oncology | 1% | 58% |

[7] Analysis includes only those CPT codes that are reimbursed by both Colorado Medicaid and Medicare; CPT codes not reimbursed by Medicare were excluded from analysis.
[8] As self-reported by providers on claims submissions. The accuracy of the provider specialty is subject to the billing provider's claim entry.
[9] Analysis excludes anesthesia codes because of the different payment methodology used by Medicare.
[10] Analysis excludes approximately 13 percent of total line items because no provider specialty was designated.
[11] Fees adjusted to Colorado geographic practice cost index.

## Exhibit B-9:
## Medicaid Fees as a Percent of Medicare Fees for Categories of Provider Specialties, Continued

| Provider Category | Provider Specialties | Percent of Line Items | Medicaid Fees as a Percent of Colorado-specific Medicare Fees |
|---|---|---|---|
| General Medicine | Allergy<br>Allergy, Pediatric<br>Dermatology<br>Emergency Services<br>Endocrinology<br>Free Standing Clinics<br>Gastroenterology<br>General Practice<br>Geriatrics<br>Immunology Infectious Diseases<br>Internal Medicine<br>Nephrology<br>Neurology<br>Neurology, Pediatric<br>Nuclear Medicine<br>Otolaryngology<br>Peripheral, Vascular<br>Physiatrist<br>Physical Medicine and Rehabilitation<br>Podiatry<br>Preventive Medicine<br>Proctology<br>Public Health Clinic<br>Pulmonary Medicine<br>Rheumatology<br>Urology | 20% | 57% |
| Vision Services | Ophthalmology<br>Optometry | 2% | 52% |
| Cardiac Specialty | Cardiology, Pediatric<br>Cardiovascular Disease<br>Cardiovascular Surgery | 1% | 48% |
| Pathology | Pathology<br>Pathology, Clinical<br>Pathology, Forensic | 1% | 38% |

## Exhibit B-9:
## Medicaid Fees as a Percent of Medicare Fees for Categories of Provider Specialties, Continued

| Provider Category | Provider Specialties | Percent of Line Items | Medicaid Fees as a Percent of Colorado-specific Medicare Fees |
|---|---|---|---|
| Surgery | Colon and Rectal Surgery<br>General Surgery<br>Hand Surgery<br>Neurological Surgery<br>Orthopedic Surgery<br>Orthopedics<br>Plastic Surgery<br>Surgery, Head and Neck<br>Surgery, Oral and Maxillofacial<br>Surgery, Pediatric<br>Surgery, Traumatic<br>Surgery, Urology<br>Thoracic Surgery | 3% | 31% |
| Radiology | Radiology | 11% | 19% |

This Exhibit shows that for SFY 2005, there is significant variation across provider specialty in reference to the percent of the Medicare fee schedule that is paid to a specialty.

The Task Force noted a concern that some physicians who may have low Medicaid fees in comparison to Medicare fees do not make a choice in their decisions to participate in the Medicaid program. Hospital-based physicians, such as radiologists, anesthesiologists and pathologists are on staff at hospitals, and provide services to anyone that has been admitted to the hospital. Unlike many of their physician peers, who may choose to not participate in the Medicaid program if fee schedules are viewed as too low, these physicians have no choice in accepting Medicaid patients.

### Paid Claims Analysis Summary

In summary, we present the following findings regarding shortfalls and disparities for the Medicaid reimbursement analysis:

- There are pronounced differences in fees among the different *types* of CPT codes. Fees for medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supplies billed with HCPCS (Healthcare Common Procedure Coding System) codes for example, are 76 percent of Medicare fees, while fees for surgery and radiology codes are 45 percent and 23 percent, respectively, of Medicare fees.

- Evaluation and Management services represent the majority of services with regard to frequency (i.e., number of services) and total payment. Evaluation and Management codes are reimbursed among the highest percent of Medicare of all codes, however, the reimbursement is still only 76 percent of Medicare reimbursement.

- Disparities exist within types of Evaluation and Management codes. The fees for the Observation and Critical Care code types, for example, are 50 percent and 58 percent, respectively, of the Medicare fee schedule. Fees for other Evaluation and Management services that are related to newborn care are higher, e.g., fees for newborn care and neonatal critical care are 92 and 89 percent of Medicare fees, respectively.

- Some differences occur on a code-by-code basis. For example, among some preventive visits (90000-series CPT codes[12]), the fees for established visits are generally higher as a percent of Medicare fees than the fees for new visits.

- The Medicare and Medicaid fee schedule differential affects specialties differently. Some providers are paid in aggregate at a higher percent of Medicare fees (Behavioral Health at 71 percent, Pediatrics at 71 percent, Family Practice at 70 percent), while others are paid in aggregate at a lower percentage (Pathology at 38 percent, Surgery at 31 percent, Radiology at 29 percent).

While some of the results presented above are mitigated by recent rate increases (i.e., SFY 2008 rate increases for all anesthesia and surgery services, therapeutic services, immunizations, DME repair and Paraguard contraceptive services as described in Table 1 ), these analyses still demonstrate shortfalls and disparities among the Colorado Medicaid physician fee schedule. Many of the disparities are the result of targeted fee increases, as opposed to systematic conversion factor updates or changes. The Department attributes the shortfalls to the constraints of the State budget.

[12] I.e., there are discrete CPT codes for preventive visits by age: infant, age 1-4, age 5-11, age 12-17, age 18-39. For each age, there are CPT codes to distinguish a new visit from an established patient visit.