Department of Health Care Policy and Financing
Targeted Rate Increase Final Recommendations
2.26.14

1. Increase Reimbursement for Pediatric Hospice Services

Rationale: The Children with Life Limiting Illness (CLLI) program provides services to critically ill children in the home, allowing clients to receive care in a more comfortable, less expensive setting. Increasingly providers are either capping the amount of CLLI services they provide or are unable to provide the services altogether due to low reimbursement rates. This option would increase provider reimbursement for CCLI services to ensure these children can continue to receive medical care in their home. The option also reduces costs by providing care in less expensive settings.

Projected Total Cost per Year: $246,878 TF; a 20% increase in the reimbursement rate.

Federal Authority: The Department will need to amend the current federally approved waiver.

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Stakeholder Feedback: Support from The Butterfly Program, Children's Hospital Colorado, Colorado Centers for Hospice and Palliative Care, Colorado Community Health Alliance, Community Connections and Denver Health

2. Increase Reimbursement Rates for Extended Hours/After Hours Care

Rationale: Often times Medicaid clients seek care after physician offices are closed for the day or on the weekends. Although the client may only require basic primary care, they must go to the emergency room (ER) to receive that care. This option provides a financial incentive for physicians to keep their offices open later and on the weekend by increasing reimbursement for care that is provide after normal business hours and on weekends. Clients will be able to receive the care they need in a less expensive setting, saving money for the state and improving health care outcomes for clients. The Department estimates there will be savings associated with this increased reimbursement based on a reduction in ER visits.

Projected Total Cost per Year: Evaluation and management codes associated with after-hours care are increased by 10% at a cost of $641,597 TF. The Department anticipates savings may be achieved with this investment by avoiding ER visit costs because those services would be delivered in a physician's office. The Department would account for any savings achieved through the regular budget process.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder Feedback: Support from Children's Hospital Colorado, Colorado Academy of Family Physicians, Colorado Community Health Alliance, Colorado Community Health Network, Colorado Medical Society, Community Connections, Denver Health, Kaiser Permanente Colorado**,** Planned

Parenthood of Rocky Mountains, Primary Care Partners, Regional Care Collaborative Organizations (RCCOs), Rocky Mountain Health Care Services, University of Colorado Denver School of Medicine

3. Fund the Transitional Living Program for Brain Injury Clients

Rationale: The Transitional Living Program (TLP) assists clients with critical injuries in returning home and integrating back into their community. The program provides both rehabilitative and habilitative care. Due to rates, there are currently no providers for this integral service within the care spectrum for individuals who have suffered a brain injury. The lack of services requires these patients to remain in the hospital for longer periods of time with eventual discharge to a more costly service option. In some cases the lack of provider participation for this service is causing incarceration and homelessness. This option would fund TLP for brain injury patients. Extending TLP to brain injury clients should serve to reduce costs by shortening hospitals stays and avoiding nursing facility admissions.

Projected Total Cost per Year: $876,000 TF; 191.28% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Stakeholder Feedback: Support from Aurora Residential Alternatives, Brain Injury Alliance of Colorado, Brain Injury Program within Division of Vocational Rehab, Colorado Cross Disability Coalition, Community Connections, Craig Hospital, Denver Health, Rocky Mountain Health Care Services

4. Increase Reimbursement for Pediatric Developmental Assessments

Rationale: If a physician determines that a child may have a developmental delay, that child must undergo a comprehensive developmental assessment prior to receiving additional health care interventions. Currently only three entities are providing these assessments to Medicaid clients. Each of these entities currently has a 6-9 month waitlist to provide the full developmental assessment. As a result, many children are not receiving the services they need in a timely fashion, resulting in missed windows of opportunity for development. This option increases the reimbursement rate for providing developmental assessments to children which will maximize the success of the interventions by increasing capacity.

Projected Total Cost per Year: $64,000 TF; a 50% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Children's Hospital Colorado, Colorado Community Health Network, Community Connections, Denver Health, Guardian Angels Health Center, Primary Care Partners

5. Increase Funding for Single Entry Point Case Management

Rationale: Single Entry Point (SEP) providers administer case management services for long term care clients throughout the state. SEP caseloads have grown significantly, reducing the ability of case managers to provide comprehensive and effective case management services for all clients. This option increases funding for SEPs to hire additional qualified case management staff. As the number of these staff increase, caseloads will fall enabling case managers to provide more person-centered service including: better assessment of need; better alignment of services; and better and more thoughtful care coordination. These service enhancements will improve the client experience, increase their quality of life, and reduce Medicaid costs.

Projected Total Cost per Year: $1,229,790 TF; a 10% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No.

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Colorado Cross Disability Coalition Community Connections, Conejos County Nursing Service, Guardian Angels Health center, Rocky Mountain Health Care Services

6. Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers

Rationale: Ambulatory Surgery Centers (ASC) can provide certain services at a lower cost and similar quality to hospitals. In an attempt to shift some volume from hospitals to ASCs, the Department previously conducted a pilot program with ASCs. The pilot increased the ASC payment rate, but the pilot did not result in a significant shift in care to ASCs. Rather than increasing payments to the ASC, this option instead creates a financial incentive to surgeons—who decide the setting of surgery—to provide the same level of care but in an ASC rather than a hospital. The Department would establish target ratios of ASC vs. outpatient hospital utilization for services that can be provided at a lower cost without compromising quality, and surgeons would be eligible to receive an incentive payment for reaching ASC targets.

Projected Total Cost per Year: $500,000 TF

Federal Authority: (SPA or Waiver required?) No.

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from Colorado Medical Society, Community Connections, Primary Care Partners

7. Increase Reimbursement Rates for High-Value Specialist Services

Rationale: Department analysis reveals that reimbursement rates for some specialty care are significantly lower than Medicare reimbursement rates. The analysis reveals Medicaid reimbursement rates for individual codes range from 3 to 99 percent of Medicare rates and 21 to 94 percent of Medicare rates for aggregated codes by specialties. Targeted increases for certain, high-value specialty care may

serve to increase specialty care access for clients and result in better health outcomes. The Department recommends the following list of codes—which were chosen from specialties who had aggregate reimbursement of 50% of Medicare rates or below—be increased to 80% of Medicare rates.

Projected Total Cost per Year: $11,312,435 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Stakeholder feedback: Support from over 95 Optometry and Ophthalmology practices across the state, Assistive Technology Partners, Children's Hospital Colorado, Colorado Community Health Network, Colorado Medical Society, Colorado Society of Eye Physicians and Surgeons, Community Connections, Denver Health, Denver Nephrology, Kaiser Permanente Colorado, Rocky Mountain Health Care Services, University of Colorado Denver School of Medicine

List of Potential Codes to Increase

Code	Description	CO Medicaid Fee as % of Medicare Fee
92002	EYE EXAM, NEW PATIENT	23%
92004	EYE EXAM, NEW PATIENT	18%
92012	EYE EXAM ESTABLISHED PAT	21%
92014	EYE EXAM & TREATMENT	21%
92018	NEW EYE EXAM & TREATMENT	18%
92019	EYE EXAM & TREATMENT	32%
92020	SPECIAL EYE EVALUATION	52%
92060	SPECIAL EYE EVALUATION	39%
92502	EAR AND THROAT EXAMINATION	22%
92506	SPEECH/HEARING EVALUATION	14%
92511	NASOPHARYNGOSCOPY	28%
92520	Laryngeal function studies	77%
92545	OSCILLATING TRACKING TEST	17%
92553	AUDIOMETRY, AIR & BONE	33%
92555	SPEECH THRESHOLD AUDIOMETRY	27%
92556	SPEECH AUDIOMETRY, COMPLETE	34%
92563	TONE DECAY HEARING TEST	16%
92565	Stenger test, pure tone	30%
92567	TYMPANOMETRY	57%
92579	VISUAL AUDIOMETRY (VRA)	42%
92585	AUDITOR EVOKE POTENT, COMPRE	65%
92601	COCHLEAR IMPLT F/UP EXAM < 7	65%
92607	EX FOR SPEECH DEVICE RX, 1HR	60%

92609	USE OF SPEECH DEVICE SERVICE	39%
92625	Tinnitus assessment	43%
93922	EXTREMITY STUDY	43%
93923	EXTREMITY STUDY	53%
93924	EXTREMITY STUDY	46%
93925	LOWER EXTREMITY STUDY	41%
93926	LOWER EXTREMITY STUDY	63%
93930	Upper extremity study	42%
93931	UPPER EXTREMITY STUDY	48%
93965	Extremity study	37%
93970	EXTREMITY STUDY	31%
93975	VASCULAR STUDY	38%
93976	VASCULAR STUDY	51%
93978	VASCULAR STUDY	46%
93979	VASCULAR STUDY	47%
93990	DOPPLER FLOW TESTING	33%
95812	EEG, 41-60 MINUTES	16%
95813	EEG, OVER 1 HOUR	17%
95873	GUIDE NERV DESTR, ELEC STIM	24%
95874	GUIDE NERV DESTR, NEEDLE EMG	25%
95928	C MOTOR EVOKED, UPPR LIMBS	39%
95929	C MOTOR EVOKED, LWR LIMBS	41%
95953	EEG MONITORING/COMPUTER	57%
95954	EEG monitoring/giving drugs	24%
95956	Eeg monitoring, cable/radio	16%
95958	EEG monitoring/function test	25%
96111	DEVELOPMENTAL TEST, EXTEND	76%
96440	CHEMOTHERAPY, INTRACAVITARY	3%
96450	CHEMOTHERAPY, INTO CNS	16%
97001	PT EVALUATION	46%
97002	PT RE-EVALUATION	55%
97003	OT EVALUATION	41%
97004	OT RE-EVALUATION	43%
97597	ACTIVE WOUND CARE/20 CM OR <	41%
G0365	VESSEL MAPPING HEMODIALYSIS ACSS	60%
G0389	Ultrasound exam AAA screen	65%

8. Increase Reimbursement for Digital Breast Cancer Screening Exams

Rationale: The American Cancer Society has identified breast cancer as the most prevalent cancer in Colorado. Advanced digital mammography offers the opportunity to identify and diagnose breast

cancers at the earliest stages before they spread into the surrounding tissue. Early stage cancers are often highly treatable, improving the chances for a cure. Raising the rates for digital mammography will likely increase the number of providers in the state who offer these services, increase Medicaid client access to these services, and ultimately improve health outcomes. We recommend three mammography codes be increase to 80% of Medicare rates.

Projected Total Cost per Year: $94,841 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Code	**Description**	**CO Medicaid Fee as % of Medicare Fee**
G0202	Screening mammography, producing direct digital image, bilateral, all views	74%
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views	64%
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views	65%

9. Increase Reimbursement Rates for Assistive Technology

Rationale: Clients with complex, chronic disabilities sometimes require assistive technology devices, such as speech generating devices, custom configured power wheelchairs, and complex positioning systems, to improve health and functional outcomes. Specialized technology assessments and trainings are needed to ensure that clients receive the most appropriate devices and learn how to use them. Medicaid clients currently have limited access to these services as very few therapists offer them; and those providers that do offer these services have restricted Medicaid appointments with long wait lists. Increasing reimbursement will remove a number of the barriers for providers and improve client access by reducing the wait time. We recommend increasing these codes to 80% of Medicare rates.

Projected Total Cost per Year: $22,037 TF

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Code	**Description**	**CO Medicaid Fee as % of Medicare Fee**
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient	26%
97542	Wheelchair management (eg, assessment, fitting, training)	53%
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report	52%

Department of Health Care Policy and Financing
Targeted Rate Increase Final Recommendations Summary Table
2.26.14

Department of Health Care Policy and Financing Targeted Rate Increase Recommendations			
Row	**Item**	**Amounts (TF)**	**Notes**
A	Increase Reimbursement Rate for Pediatric Hospice Services	$246,878	20% rate increase to increase provider participation for critical pediatric hospice services
B	Increase Reimbursement Rate for Extended Hours/After Hours Care	$641, 597	Increase evaluation and management codes associated with after-hours care by 10%
C	Fund the Transitional Living Program for Brain Injury Clients	$876,000	191% rate increase; currently zero provider participation at current rate, will facilitate transitioning clients back into their home and community
D	Increase Reimbursement for Pediatric/Developmental Assessment	$64,000	50% rate increase to increase provider participation for critical pediatric developmental assessments
E	Increase Funding for Single Entry Point Case Management	$1,229,790	Increase funding by 10% to deal with significant increases in case management services for long term care clients
F	Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers	$500,000	Increase Ambulatory Surgery Centers utilization by incentivizing surgeons to perform surgeries in lower cost setting
G	Increase Reimbursement Rates for High-Value Specialist Services to 80% of Medicare	$11,312,435	Increase specific high-value specialist rates to 80% of Medicare to increase specialty care access for clients and result in better health outcomes
H	Increase Mammography Reimbursement Rate to 80% of Medicare	$94,841	Increase specific mammography rates to 80% of Medicare to increase access for clients and increase provider participation
I	Increase Assistive Technology Reimbursement Rate to 80% of Medicare	$22,037	Increase specific assistive technology rates to 80% of Medicare to increase access for clients and increase provider participation
	Total Department of Health Care Policy and Financing Targeted Rate Increase Recommendations	**$14,987,578**	

Notice: The Colorado Department for Health Care Policy and Financing (Department) is seeking stakeholder input regarding potential targeted rate increases using funds that may be appropriated. Approximately $19 million may be available for targeted rate increases in FY 2014-2015.

The ultimate decision on moving forward with a 0.5% increase is dependent upon Joint Budget Committee (JBC) approval. Even if we do not receive JBC approval to move forward with this request, we do plan to use the information you submit to us to help inform future budget and policy requests.

It is our intention for this to reach all interested stakeholders. Please distribute this to anyone who may be interested in submitting a proposal to the Department or interested in participating in this process.

Any rate increase(s) MUST be implemented no later than July 1, 2014**. Stakeholders are asked to submit their input on or before 5pm, Friday, January 31, 2014 to allow the Department sufficient time to review their input.**

Below please find the intended purpose of the rate increase and guidelines for submitting input.

Purpose: Targeted rate increases should:

- promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or
- address inappropriate provider reimbursement rates to improve client access to cost-effective care.

The Department has identified an initial list of rate increase options intended to promote high-value, cost effective care and/or serve to alleviate some access to care issues related to inappropriate reimbursement rates. This initial list is based on client and provider feedback as well as Department analysis.

The Department requests your input on the list of options attached to this notice. Additionally, the Department welcomes your suggestions for rate increases that will result in high-value, cost effective care and/or will address access to care issues that stem from low reimbursement rates.

Guidelines for Submitting Input:

The attached list of rate increase options contains information regarding the rationale, cost, projected timeline for implementation, and related information.

A. Please consider each option on the list and respond to the following questions <u>for each option</u>:

    1. Do you support or oppose the option?

a. If you support the option, please explain how the proposed increase will accomplish the following goals:
    i. Ensure or improve client access to care
    ii. Incentivize more providers to deliver the service(s)
    iii. Improve quality health outcomes for Medicaid clients
    iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

2. If you do not support the option, please explain why.

B. Please provide your recommendations for a rate increase(s) that:

a. promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or

b. address inappropriate provider reimbursement rates to improve client access to cost-effective quality care.

Each rate increase recommendation should be limited to 2 pages and should include the following information.

a. Specific service or units of service recommended for an increase

b. Percentage and dollar amount of the recommended rate increase

c. Known challenges and barriers to implementation, including the need for state legislative or regulatory changes and/or federal approval.

d. Explain how the proposed increase will likely:
    i. Ensure or improve client access to care
    ii. Incentivize more providers to deliver the service(s)
    iii. Improve quality health outcomes for Medicaid clients
    iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

e. Would the Department be able to implement the increase by July 1, 2014?

f. Is the proposed increase operationally and programmatically feasible and sustainable?

Please note the Department must select rate increase option(s) that comply with legal requirements and are operationally feasible. When selecting options, the Department must consider whether major system changes would be required and the associated cost and timeline for those changes. Only rate increases that are able to be implemented on or before July 1, 2014 can be selected.

The 0.5% increase is dependent upon Joint Budget Committee (JBC) approval. Even if we do not receive JBC approval to move forward with this request, we do plan to use the information submitted to help inform future budget and policy requests.

Please submit feedback to: Medicaid2015@state.co.us

Input must be received by the Department by 5pm, Friday, January 31st.