Option: 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, 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.

Option: 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 Impact: \$58,927 in savings. The estimate is based avoiding 5% of ER visit costs because those services would be delivered in a physician's office. Evaluation and management codes associated with after-hours care are increased by 10% at a cost of \$\$641,597. The savings of reducing ER visits by 5% is \$700,491.

Federal Authority: (SPA or Waiver required?) No

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

Option: 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. 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.

Percent Rate Increase: \$876,000. A 191.28% increase in the reimbursement rate.

Projected Total Cost per Year: \$876,000.00

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.

Option: 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 with the goal of incentivizing more entities to provide these assessments.

Projected Total Impact: \$64,000, 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.

Option: 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.

Project Total Impact: \$1,229,790, a 10% increase

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

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

Option: 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.

Project Total Impact: \$250,000 - \$500,000

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

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

Option: 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 are currently reimbursed at 65% of Medicare rates or below—be increased to 80% of Medicare rates and requests stakeholder input on how best to target the increases.

Projected Total Impact: \$11,312,434.52

Federal Authority: (SPA or Waiver required?) No

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

List of Potential Codes to Increase

Procedure 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 ** see	SPEECH/HEARING EVALUATION	14%
note below		
92521	SPEECH/HEARING EVALUATION	14%
92522	SPEECH/HEARING EVALUATION	14%
92523	SPEECH/HEARING EVALUATION	14%
92524	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%
**	92506 is no longer valid and has been replaced by codes 92521-24	