COLORADO
Department of Health Care Policy & Financing

Appendix I - Stakeholder Feedback

Appendix I contains all public stakeholder feedback that HCPF has received via email and verbally at the Medicaid Provider Rate Review Public Meetings. Email feedback is verbatim and unaltered from public stakeholders and did not undergo editing or factual verification by HCPF. All verbal feedback has been summarized to the best of HCPF's ability. The feedback in this appendix may not reflect HCPF's views and opinions on the rates of the Year 3 Services under review.

The feedback in this appendix was collected from October 1, 2024 through October 1, 2025.

Some feedback was redacted, edited, or removed due to Protected Health Information (PHI).

All meeting recordings and meeting minutes can be found on HCPF's Rate Review website.

COLORADO
Department of Health Care Policy & Financing

Dialysis and Dialysis-related Services

Jackson Williams
Dialysis Patient Citizens

Dialysis Patient Citizens (DPC) writes to offer its comments on the Medicaid Provider Rate Quarterly Review with respect to dialysis reimbursements.

DPC's membership, currently about 30,000, is restricted to kidney disease patients and their family members. DPC is a patient-led organization. Our by-laws require that the President, Vice President and at least 51% of the Board be current dialysis patients. The non-dialysis patients serving on our Board are former dialysis patients with kidney transplants. Our volunteer board members have represented their peers on CMS technical expert panels and/or advisory committees of other health care organizations such as the National Quality Forum and Patient- Centered Outcomes Research Institute. DPC also conducts periodic Membership Surveys to ascertain patients' experiences with their care and views on health policy issues. DPC is committed to promoting access to high-quality dialysis care for individuals with ESRD; to prevention of, delayed onset of, and safe transition to ESRD among individuals with chronic kidney disease; and access to kidney transplantation as well as to other alternatives to dialysis that may emerge.

DPC has 905 members in Colorado. As America's healthiest state, Colorado has a low incidence rate of end-stage renal disease but a disproportionately higher prevalence rate, as Colorado patients tend to live longer on dialysis than their counterparts elsewhere.

During the recent years of rising inflation and labor shortages, CMS' updates to Medicare payments for dialysis significantly lagged increases in input costs. Last year, CMS granted a net increase in the base rate of only 0.8% for a year in which wages, according to Bureau of Labor Statistics, rose 4.2%.

The Medicare Payment Advisory Commission this month found that dialysis providers' Medicare margin was -1.1 percent in 2022 and -0.2 percent in 2023. The Commission projects a 2025 margin of 0 percent with many rural and low-volume facilities operating in the red. This occurs at a time in which a Supreme Court decision has emboldened many employers to gut their insurance coverage for dialysis, further weakening the financing of our nation's precious kidney care infrastructure.

Needless to say, for Medicaid payments limited to just 80% of Medicare rates, it is important to update payments to mitigate clinics' losses when serving a very vulnerable population.

We would like to take this opportunity to discuss the issue of healthcare workforce shortages and the need for robust federal and state commitments to paying these essential workers commensurate with their value to society. According to a ZipRecruiter analysis of Labor Department data, health care has one of the most severe labor shortages among U.S. industry sectors, with 55.6% of job openings unfilled and just 0.29 unemployed workers per opening.

In 2023 we collected survey data and beneficiary reports illustrating how dialysis patients were impacted by acute workforce shortages in the wake of the pandemic. What dialysis patients saw firsthand was how fragile our health care system is and perhaps a preview of future years.

CMS statistics show increases in the median time patients spent in an Emergency Department. The hospital industry reports that there are 94,000 fewer workers at hospitals than there were four years ago. Comparing numbers from a 2017 survey on physician appointment wait times by Meritt Hawkins to a 2024 secret shopper study conducted by ECG Management Consultants, average new patient physician appointment wait times have increased significantly. In 2024, the average wait time for the third next available appointment across 11 medical specialties in 23 U.S. metro areas was 38 days.

It is delusional to think that bare-bones Medicare reimbursements, which continue to fall short of inflation, and lower-still Medicaid reimbursements, will allow health care providers to offer competitive compensation as secular demographic factors shrink the pool of available workers.

According to BLS's most recent forecast, "The slower birth rates of the 1970's will cause the population ages 55 to 64 to decrease much faster than any other age group. Meanwhile, the 65 and older age group will experience fast growth as all baby boomers age into that category by 2032. This age group's projected 14.4 million increase in population accounts for over three quarters of the overall projected population growth. Of that 14.4 million increase, about 10.6 million comes from the 75 and over age group, as most of the baby boomers age into that Bracket. "Slower projected growth in the population is expected to constrain growth in the civilian labor force over the projections period... The labor force participation rate is projected to fall from 62.2 percent in 2022 to 60.4 percent in 2032. The

principal factor driving the projected decline in the labor force participation rate is a greater share of individuals over the age of 65."

BLS projects that healthcare will account for 45% of all new job openings by 2032. We worry that policymakers' failure to take labor shortage dynamics seriously will severely hinder providers' ability to fill those positions. Of course we realize that many occupations comprise "essential workers" and we do not suggest that healthcare vocations' value trumps, say, the value of first responder or national defense vocations. But all such positions, mostly funded by government, provide outsize value to our society and must be compensated in proportion to that value, lest they go unfilled.

Thank you for your consideration of our views.

Rob Sikorski
DaVita

DaVita Inc. ("DaVita") appreciates the opportunity to submit comments to the Medicaid Provider Rate Review Advisory Committee ("MPRRAC") for provider Medicaid rates currently under review. DaVita provides quality life-saving care to patients diagnosed with kidney failure, also known as End Stage Renal Disease ("ESRD") and has the privilege of caring for 2,500 Coloradans in need of dialysis care, including many Medicaid recipients, across our 36 outpatient clinics in the state. Additionally, DaVita is proud to call Colorado home with our world headquarters located in downtown Denver. We are one of the largest providers of dialysis services across the U.S., providing care for 208,000 patients nationally.

DaVita respectfully requests MPRRAC consider increasing the hemodialysis reimbursement rate for treatments billed with revenue codes 821, 831, 841, and 851. A rate increase for dialysis providers in Colorado would be consistent with the program's goal of meeting an 80% benchmark of a provider segment's Medicare Fee-For-Service ("FFS") rate and will help ensure the state's provider network remains strong.

In the 2023 rate review year, Medicaid raised rates in two Colorado regions by over 10% (18.6% in Boulder and 13% in Fort Collins). Additionally, Greeley received a rate increase of 9.3%. Due to the three-year review cycle, these increases were implemented to align Colorado Medicaid with methodology changes to the Medicare

Prospective Payment System during non-review years. In order to meet Colorado Medicaid's stated benchmark of 80% of the Medicare FFS rate, reimbursement rates in several regions would require substantial increases in 2026. For example, the Colorado Springs region would require a 14% increase in 2026 to meet the benchmark. Similarly, the Denver and Rural Colorado regions would require increases of 8.7% and 7.4% respectively to meet the target. Currently, DaVita's average Colorado Medicaid reimbursement rate for hemodialysis is $221.02 per treatment.

It is also important to note that given changes in the wage index methodology for Medicare FFS in 2025, absent regional rate increases, Colorado Medicaid will fall even further behind its 80% Medicare pricing benchmark goal (Colorado Medicare FFS rates will see a 3.4% total increase in 2025).

DaVita, like most other healthcare providers, has been adversely impacted by a combination of the lingering economic effects of the COVID-19 pandemic, unprecedented inflation, and high labor costs due in part to continued staffing challenges we have seen throughout the country and especially in Colorado. When faced with operational challenges, providers may be forced to reduce the availability of dialysis treatment times or consolidate clinics, which in turn could make it more difficult for dialysis patients in the state to access and receive dialysis care. Any disruption in treatment, especially those clinics in rural areas of the state, can lead to serious health complications. Dialysis patients are a vulnerable patient population and studies show that even one missed treatment is associated with a 40 percent greater risk of hospitalization and more than doubles the risk of mortality in the subsequent 30 days. Given these factors, it's vital for state Medicaid reimbursement rates for hemodialysis to be adjusted.

DaVita respectfully requests that MPRRAC increase the hemodialysis reimbursement rate to better align with the Medicare FFS rate and address the financial and operational challenges that dialysis providers continue to face in today's healthcare climate. DaVita welcomes the opportunity
to further discuss these comments and looks forward to collaborating on this matter.

DaVita PowerPoint Attachment

Wendy Schrag
Fresenius Medical Care

Fresenius Medical Care provides life sustaining dialysis to 1,755 Coloradans in 27 outpatient dialysis clinics.
This is the number of patients we serve with Medicaid in the following categories:

- Primary Medicaid: 216 (10%)
- Primary Medicaid Managed Care: 45 (2%)
- Secondary Medicaid: 490 (23%)
- Secondary Medicaid Managed Care: 64 (3%)

Most of the patients we serve with Medicaid as their primary insurance have fee for service Medicaid vs managed Medicaid. Colorado's current fee for service payment per treatment is $228. That is well under our cost per treatment of $348. This results in an annual loss per patient of $17,000. Colorado also coordinates secondary payment. We get some reimbursement for our 490 patients who are dually eligible for Medicare and Medicaid but not the full 20%.

We request an increase in codes 821 (In Center Hemodialysis, Home Hemodialysis, Home Hemodialysis Training), 841 (Continuous Ambulatory Peritoneal Dialysis (CAPD) & Training), and 851 (Continuous Cycling Peritoneal Dialysis (CCPD) & Training) to close the gap in the amount that we lose serving each patient with Medicaid as their primary insurance.

We also request an expansion of Colorado's managed Medicaid plans. There are only two options for managed Medicaid plans and they are county specific and not available for all of our patients. According to a recent study by Kaiser Family Foundation, 75% of Medicaid beneficiaries nationwide are in a managed care plan. Colorado is one of only 5 states that has less than 50% of its Medicaid population in a managed care plan. Especially for complex medical conditions like kidney failure, managed Medicaid may help to manage costs, utilize resources effectively, and ensure quality care.

References:
Elizabeth Hinton and Jada Raphael. 10 Things to Know About Medicaid Managed Care. Kaiser Family Foundation, February 27, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Wendy Schrag
Fresenius Medical Care

Thank you for your decision at the July meeting to bring some codes up to the 80% of Medicare amount. In addition, we request an increase above the 80% of Medicare amount for codes 821 (In Center Hemodialysis, Home Hemodialysis, Home Hemodialysis Training), 841 (Continuous Ambulatory Peritoneal Dialysis (CAPD) & Training), and 851 (Continuous Cycling Peritoneal Dialysis (CCPD) & Training) to close the gap in the amount that we lose serving each patient with Medicaid as their primary insurance.

Dental for People with Intellectual and Developmental Disabilities (DIDD)

Stephen Rogers, D.D.S

Dear Members of the Medicaid Provider Rate Review Advisory Committee,

I am writing today to express my deep concerns with proposed cuts to Medicaid dental rates in HCPF's state budget request. I am a dentist at Lakeside Kids and Special Needs Dentistry, working alongside Dr. Shaheen Moezzi, who is providing verbal testimony on this matter. Our clinic relies heavily on Medicaid funding. With the new rates that were approved by the legislature last year, we've expanded our clinic and hired more providers.

In October, we provided dental exams and procedures for 57 patients with special needs, and we are able to deliver high quality care by very experienced providers. Our facility provides high quality dentistry to adults and children with IDD, through experienced dental providers who are in a community-based setting. This allows for continuity of care outside of an institution or hospital.

The Medicaid rate increase allowed us to build out a second operating room this summer and recruit additional dentists and anesthesia providers. We doubled our capacity this past summer. Our wait time was previously 6-9 months to treat these patients. Our wait list is down to 3-4 months currently.

Appropriate rates allow for more community-based settings to provide care for these patients with special needs, which can help avoid costly emergency room and hospital visits. Even with the greatly appreciated rate increases of this past year, there is still a substantial unmet need for the special needs population. Cutting these Medicaid rates now would only exacerbate the existing challenges for this vulnerable population to access care. I urge you to oppose the proposed cuts to dental rates and share your opposition with the Joint Budget Committee.

Thank you for your work on these important issues.

Peter Shelley, D.D.S

Dear Members of the Medicaid Provider Rate Review Advisory Committee,

I am writing to express my concern over the proposed reductions in Medicaid reimbursement rates for dental codes, specifically for endodontic procedures and related services.

I'm specifically concerned about the D3330 code and similar endodontic and endodontic retreatment codes. I was also talking with a general dental colleague and he said if he refers his patient to a Medicaid endodontist provider it takes at least three months for them to get treatment due to lengthy waitlists. As you know, endodontic needs often require emergency and timely treatment, and there is clearly a backlog of cases and need for providers. In addition, when patients in pain can't get timely treatment, they are given antibiotics and prescription pain meds, neither of which are good for either the individual or for society.

I earnestly urge you to strive to keep the reimbursement rates at or above their current levels. Support in this matter is vital for the continued provision of high-quality endodontic care to Medicaid patients.

Lauren Harvey
Colorado Dental Association

I hope you're well today. Thanks for reaching out about the DIDD Dental rate review.

CDA's Medicaid committee discussed this and would like to share this feedback:

1. 1. We agree about using the ADA 2022 data (with necessary adjustments if required), as that represents the reality of costs to provide services.
2. We also suggest another option of using the CO Dept of Labor and Employment Division of Workers' Compensation 2025 Medical Fee Schedule – Exhibit 3 Dental fees. This medical fee schedule has been vetted by the state government, and could be considered similarly to a disability as its intended for those who are injured/temporarily disabled.
3. If other states are utilized for review/comparison, it would be important to us to know how those other states set their Medicaid rates. On that note, we know that Delaware bases their Medicaid dental fee schedule on the National Dental Advisory Service (NDAS) annual Comprehensive Fee Report, which is also a good representation of actual cost for services.

Thank you and please let me know if you have questions for us, or how else we can assist in your analysis.

Kevin M. Patterson, D.D.S., MS
Colorado Dental Association

I am submitting this testimony in response to the proposed cuts to adult dental Medicaid rates, which were only recently raised to an acceptable level after extensive collaboration between the Colorado Dental Association (CDA) Medicaid Committee, the Colorado Department of Health Care Policy & Financing (HCPF), and MPRRAC. The work of this Advisory Committee was essential to increasing access to oral healthcare for all Coloradans, and I appreciate the care and expertise you all put into advocating for increased dental rates in the Medicaid program.

I submit this testimony as the current President of the Colorado Dental Association and a practicing oral-maxillofacial surgeon who has been a Medicaid provider since completing my residency and medical school in 1998.

As an oral-maxillofacial surgeon who provides hospital and emergency room coverage for seven Front Range hospitals, I see firsthand how the lack of accessible oral healthcare puts uninsured Colorado residents at significant risk for severe oro-facial infections. These infections, when untreated, can escalate to a serious health crisis requiring aggressive and costly operating room interventions. Left untreated, these infections often necessitate invasive treatment to drain abscesses in the head and neck, potentially leading to extended ICU stays or even death.

Most of these infections could have been prevented with access to routine preventive and restorative dental care, or timely endodontic treatment, which would address the dental issues before they become surgical emergencies. For years, inadequate reimbursement rates discouraged providers from enrolling in Medicaid, leading to a shortage of dental providers willing to offer necessary care for low-income individuals in Colorado.

The recent increase in reimbursement for a selection of preventive, restorative, and endodontic codes was a crucial step forward. It brought real hope to our mission to improve the oral health of Coloradans. With these new rates, the CDA has been able to collaborate more effectively with HCPF and DentaQuest to encourage more providers to enroll in Medicaid. This progress, given sufficient time, would result in increased access to essential dental care, including preventive, restorative, and endodontic services, for thousands of Coloradans in need.

Colorado's dental Medicaid program is uniquely cost-effective: the state pays only 20 cents on the dollar, with the federal government covering the remaining 80% of Medicaid dental expenses. This means that for every dollar cut from Colorado's Medicaid dental program, the state loses four dollars in federal funding. Put another way, for every five dollars of dental care provided under Medicaid, Colorado pays only one dollar. Cutting $1 million from adult dental Medicaid, therefore, results in $5 million of care lost to the state's most vulnerable residents.

What began as a significant victory for Colorado Medicaid enrollees is now at risk of becoming a devastating setback. The CDA has worked tirelessly to emphasize the importance of Medicaid enrollment, providing guidance to both members and non-members through the often-complex enrollment process. The recent rate increase was positively received by providers, resulting in a noticeable increase in dentists willing to enroll or consider enrolling in Medicaid. However, this momentum will not be sustained if the proposed cuts are approved.

For these reasons, we urge you to express your opposition the proposed cuts to dental Medicaid funding. Colorado's Medicaid recipients deserve consistent access to preventive, restorative, and endodontic care, which not only improves their quality of life but also reduces the costly emergency interventions that arise from deferred dental care.

Lauren Harvey
Colorado Dental Association

The Colorado Dental Association appreciates the work of the MPRRAC and your support for access to dental care. The MPRRAC may have seen a press release from CIVHC - Colorado's All Payers Claims Database - regarding a new resource now available to the public on dental fees and payments. That data, which was already reported to the state through mandatory reporting, is now available in a public dashboard on CIVHC's website: https://civhc.org/get-data/public-data/dental-health-analysis/. This resource may be useful for future legislative and budget discussions on dental rates, particularly in lieu of the now-defunct ADA fee survey.

CDA appreciates the MPRRAC identifying those DIDD codes that have reimbursement set below the Medicaid dental codes, and prioritizing those codes for increases. As noted at the July 18 MPRRAC meeting, CDA advocated to look at the nexus of higher utilization DIDD codes and those which are undervalued compared to Medicaid dental codes. Based on DIDD code utilization data we received from HCPF, a few codes that

stand out for higher utilization and lower reimbursement are: D1110 Prophylaxis adult; D1206 Topical Fluoride Varnish; D4910 Periodontal Maintenance; D4342 Periodontal scaling 1 to 3 teeth; D4341 Periodontal Scaling & Root planing. These are just a selection of codes that have higher utilization and lower reimbursement. We agree with the MPPRAC's overall goal that all DIDD codes should be set above Medicaid codes. Additionally, there are some anesthesia related codes that do not appear to be on the DIDD fee schedule at all, but it should be noted that these procedures require more time, effort, and collaboration to ensure safe treatment for the IDD population, given their often complex medical histories. Those anesthesia codes that don't appear to be included in the DIDD fee schedule are: D9219 Eval for deep sedation/general anesthesia; D9222 Deep Sedation/General anesthesia first 15 minutes; D9223 Deep sedation/general anesthesia each 15 minute increment. Thank you for your work on this and for allowing us to provide comment.

Durable Medical Equipment (DME)

Kelli Ore
CAMES

Good afternoon members of the committee, and members of HCPF, my name is Kelli Ore, and I am representing CAMES today. My employer provides respiratory, sleep therapy, enteral nutrition, and many other DME services for the entire state. We have 26 locations in Colorado, several in small rural communities, and in some of our locations, we are the only provider of the above-mentioned services.

As a former MPRRAC board member, I would first like to thank you all for your dedication, time, and thoughtful investigation of the categories of service currently under review. I understand the severity of rate recommendations, and the potential impact on providers and suppliers to keep participants safe, healthy, and in their homes.

As many of you know, Medicare rates are based on covered services and were designed for a population of patients at or above age 65, not to mention the rates established by the flawed competitive bidding implementation.

The DME PDAC (which stands for Pricing, Data Analysis and Coding) reviews a DME item to determine which healthcare common procedure coding system (HCPCS code) the item falls into, with no consideration for covered vs non-covered, cost, or reimbursement. If there is a code that best describes the item manufactured, the item is classified or designated under that code. For example, B4155 has 474 items that are classified under that one code. All 474 manufactured items have drastically different costs to the supplier, but the reimbursement is the same. More than half of the items classified under this code are not covered by Medicare. This is just one example of hundreds of codes that fall into this scenario.

There are several hundred formulas manufactured for complex metabolic conditions, organic blends, and food allergens for infants, pediatric, and youth participants that would be impossible to provide if the rates are adjusted to the benchmark. Eliminating the ability to provide these critical formulas would jeopardize the health of this population.

The federal government matches DME expenditures by Colorado Medicaid for the pediatric population (up to age 21) at 100% which has allowed for some additional

consideration in rates for items that aren't typically covered by Medicare and/or the Medicare rates are insufficient for the codes due to the population majority being serviced within the scope of the code.

For HCPCS K0739, DME providers worked with HCPF, and the disability community to establish a fair and equitable rate that allowed DME suppliers to conduct repairs in the homes of Colorado Medicaid participants. Many participants are unable to bring their equipment to a supplier to conduct repairs due to lack of transportation, and/or the inability to transport the item. Suppliers of CRT, and other items requiring repair by a skilled technician are only reimbursed for the time they spend repairing a piece of equipment in the home, regardless of the time spent driving to various locations.

An example of the current rate vs the benchmark rate is sending technician to the home to conduct a minor repair to a DME item:
A 2.5 hour round trip drive, and two units of K0739 = $58.34 at the current rate, and $32.10 at 100% of Medicare rates. The cost to the supplier for just the hourly wage of a skilled technician at $22.00/hour (which is the low end of wages for a skilled technician) = $55.00

The example given doesn't take into consideration the additional cost for fleet management, tools, gas, insurance, etc. Suppliers cannot sustain losses in every scenario and stay in business; therefore, the only solution would be to eliminate the service or narrow their service area. Our organization has worked with HCPF for decades to transparently show our costs for these items and services and establish rates that allow a broader service reach to all participants in Colorado.
We understand the fiscal responsibility for the current budget, and preservation of the Medicaid program for our future. We aren't coming to you today asking for rate increases, we are asking for preservation of the current rates to allow suppliers to continue to service every participant in Colorado. Reducing the rates to the benchmark for the codes that currently exceeds them will result in suppliers exiting the program and leaving participants with an inability to obtain the DME that allows them to be independent at home and in our community.

I appreciate the opportunity to speak with you today, and I look forward to answering any questions that you may have.

Craig Hospital

Craig Hospital appreciates the opportunity to provide input regarding the Medicaid

Provider Rate Review Advisory Committee's (MPRRAC) current review of durable medical equipment (DME) codes, including complex rehabilitation technology (CRT) and enteral nutrition supports.

As a nationally recognized center for specialty rehabilitation of individuals with spinal cord injury and brain injury, we serve a population with highly specialized and ongoing
clinical needs. Many of our patients require access to customized DME—particularly CRT and nutritional support equipment—in order to maintain health, mobility, and independence in the community.

Access to timely, individualized, and high-quality DME is essential to the long-term stability of these individuals. The availability of this equipment often determines whether someone can safely live at home, avoid unnecessary hospitalizations, and participate meaningfully in their community. Limitations or delays in access to appropriate DME can lead to avoidable complications, higher health care costs, and reduced quality of life.

While we defer to the appropriate stakeholders to address questions of reimbursement methodology, we want to emphasize the critical clinical role DME plays in helping individuals with complex neurological injuries remain safely supported outside of institutional settings. Any policy changes under consideration should carefully account for the impact on access to this medically necessary equipment.

We appreciate MPRRAC's ongoing efforts to ensure that Medicaid services remain accessible, appropriate, and responsive to the needs of Coloradans with disabilities.

Paul Hogfeldt
CAMES

Good Morning/Afternoon, members of the committee and HCPF. My name is Paul Hogfeldt, and I serve as President of the Colorado Association of Medical Equipment Services (CAMES), representing durable medical equipment providers across our state. Durable Medical Equipment (DME) such as ventilators, oxygen, power wheelchairs, wound care, and enteral supplies are critical for Medicaid members, allowing them to live and thrive in their homes instead of institutional settings like hospitals or nursing facilities.

CAMES and our providers understand the need for responsible fiscal management of Medicaid funds and take our role very seriously. The services we provide are crucial in keeping Medicaid members at home where they prefer to be and is the most cost-effective setting while achieving positive health outcomes.

Over the past 20+ years, CAMES has worked closely with Colorado Medicaid on rate setting, providing open discussions on provider costs to furnish DME items. This transparency has resulted in the current rates compared to the proposed benchmarks.

In 2013, Medicare implemented the Competitive Bidding Program. This program is a federal cost-containment initiative that sets reimbursement rates for DME based on the lowest bids submitted, without accounting for quality of service or experience of the suppliers awarded the bids. Essentially, it's a race to the bottom of patient care in an effort to save funds resulting in unsustainably low rates that don't reflect actual provider costs, especially in rural or underserved areas. The competitive bidding program has led to a 17.3% reduction in the number of DME providers in Colorado over the past decade. Since 2018, Colorado Medicaid has aligned many of its DME rates with Medicare's competitive bidding program, resulting in rate reductions up to 30% for essential equipment and supplies, while the cost to deliver the services has risen dramatically, especially during the period of the PHE and those costs have not rebalanced post PHE.

Inflation has driven up fuel, freight, labor, and supply costs by over 34%, and proposed tariffs on medical goods threaten to raise costs even further. A recent example of this was the announcement of a 10% cost increase from a major enteral pump and supply manufacturer that went into effect on July 1st.

I grew up in a home with multiple siblings with special needs who used ventilators, oxygen, mobility equipment, and enteral supplies. Without access to these items, my siblings would have had to live full-time in a hospital.

Rebalancing the DME rates that are over the benchmark by utilizing flawed rates will yield a significant access to care impact on all Colorado Medicaid participants. Limiting access to crucial services in the home setting, where the cost can be 50-80% less expensive than a facility, is not the answer.

We urge the committee to consider the real-world consequences of further rate reductions. Without sustainable rates, we risk losing even more providers, and with them, the ability to serve Colorado's most vulnerable residents. Thank you for your time.

Prosthetics, Orthotics, Enteral Formula, and Other & Disposable Supplies (POS)

Trina Bassak
About Kids Physical Therapy

I am a physical therapist in the state of Colorado and wanted to reach out to let you know how integral cranial remolding orthosis are to the plan of care for the little ones that qualify. In my over 30 years experience, these infants and toddlers that have the orthosis progress more rapidly and reach their goals for improved symmetry and muscle balance during development. This allows them to progress in their gross motor skills with more normal movement patterns. Particularly, infants with torticollis will benefit as it allows them to move more symmetrically especially for rolling while their cranial structure is being remolded. This in turn allows them to develop better eye hand coordination for reaching on both sides. The orthosis assist in laying the foundation for development in many areas including gross motor, fine motor, visual motor with more symmetry and avoiding muscle imbalance that will interfere with normal movement patterns. It is a very multi-disciplinary approach to treating development of the infants/toddlers with head shape anomalies and the orthotist involved in their care is essential.

As each orthosis has to be custom measured to fit the infant/toddler, critical components to be considered include the time required for fitting/fabricating, orthotist education and competence, orthotist experience and materials required as well as the frequent adjustments that are made with growth. I am sure there are other pieces I have not considered in addition to those mentioned. The rate for S1040 cranial remolding orthosis is appropriate and in today's rising costs, may even be low.

I am sorry to not be able to attend the virtual review due to scheduling conflicts but am happy to provide additional information if needed.

Tim Littlefield, CTSO

My name is Tim Littlefield, and I am a biomedical engineer and have been exclusively involved in the care of infants with plagiocephaly for nearly 30 years. While others will be providing information on the clinical aspects of this treatment, my purpose

today is to share with you some of the regulatory, design, and manufacturing considerations for these products.

While it is not uncommon for people to look at these devices and conclude they are just a simple piece of foam and plastic, the opposite is quite true. These devices are highly regulated by the Food and Drug Administration as Class II (medium risk) neurological devices which require additional controls to ensure they are both manufactured correctly, and that clinical care is provided properly. They were classified this way because the FDA understood that this is a very special treatment population we are dealing with, infants, who are unable to communicate with rapidly growing heads, and only a small window of time (3 -12 months) to correct their deformity.

The manufacturing of these devices is performed in FDA registered facilities, which undergo regular inspection to ensure the devices are made in compliance with 21 CFR 820 Quality System (QS) requirements. These requirements cover the full life cycle of the product from design, purchasing, production, inspection, auditing, training, validation, corrective actions, compliant handling...the list goes on. In total there are roughly 25 subsections to our Quality System, all of which need to be overseen by a large quality department.

From a manufacturing perspective, it should be appreciated that these are not off-the- shelf; small, medium and large mass-produced devices, but are in fact custom-made to address each patient's unique deformity. Production requires many sophisticated technologies from advanced 3D imaging systems to custom AI/Machine Learning design software, to CNC controlled machining centers and vacuum forming equipment.

Along with their custom nature, I also wanted to highlight that these devices are also very time sensitive to produce – we have 7 to 10 calendar days from when we take the original 3D image to have the finished product back in the clinic for fitting by the clinical staff. As this often includes a weekend and shipping time, it means that we have only 2 to 3 days to produce the device in manufacturing.

After the initial fitting of the product, each patient is followed throughout the course of their treatment. We know how every baby is doing, and if something isn't right we take action quickly. These products are under warranty, and if any product needs to be remade, for any reason (illness, dog chewed the band, etc.), the third-party payor will not be billed.

As you can see, there is actually a lot of time, effort, and oversight that goes into the design and manufacturing of these devices. Not even considering the clinical time and effort, or the looming tariff uncertainty, we feel that the current reimbursement rate is fair and appropriate and recommend that the rate remain unchanged at this time.

Thank you again for the opportunity to share this information.

Chella Leicht
Premier Kids Care

We are provider with Virginia Medicaid. Our NPI number is 1447321674.

Our Company, Premier Kids Care, is enrolled as a DME provider with CO Medicaid. I am reaching out to you in an effort to negotiate a better rate for codes A4231 (steel infusion sets) which are supplies that go with the Insulin pump.

We really need some help. The pediatrics members of CO Medicaid which we take care of with type 1 diabetes are being prescribed steel canula infusion sets (code A4231) that go with their insulin pump. The Doctors choose or change patients to the steel infusion sets (A4231) because the plastic canula infusion sets (Code A4230) tend to kink, and patients end up with an infection and could end up in the hospital. They also tend to fall out because patients are skinny, frail, play sports, etc.

CO Medicaid reimburses below our cost on the steel infusion sets (code A4231). We are seeing more patients being prescribed or having to change to the steel canula because of all the issues. Would you consider negotiating a better reimbursement rate for code A4231? Please find attached some information about the differences between infusion sets.

I have attached some information concerning the different infusion sets. I can send some clinical information as well.

Thanks for your consideration.

Summary of why we are requesting to renegotiate reimbursement rates on these two codes:

- *Code A4231 – We are being reimbursed lower than out cost. This is a steel infusion set, and we must pay more for this infusion set than we do the*

soft/plastic infusion set and it is reimbursed substantially less. The soft infusion set (code A4230) reimburses at a better rate. We are asking that you increase the reimbursement for code A4231 at least to the same amount of reimbursement as code A4230.

Jim Melancon
Aveanna Healthcare

On behalf of Aveanna Healthcare and our Medical Solutions division and our Colorado patients and families to whom we provide services, we support the rate recommendations made by MPRRAC for this category [Other & Disposable Supplies] and would urge HCPF to adopt the recommendations.

Kristen Thessing
Cranial Kids

Link to feedback 1
Link to Feedback 2

Maggie Baumer
Hanger

Thank you for your patience. We created the attached spreadsheet listing the states with which we recommend Colorado align itself in terms of prosthetic and orthotic code reimbursement. We had one recommendation for a code addition, L2006, which describes a custom fabricated, single or double upright KAFO with an adjustable microprocessor control feature which provides resistance to stance and swing phase knee joint motion (see attached info from CMS on pages 15 and 16 for the rationale behind the coverage and payment of this category of devices).

For codes without a Medicare rate, we recommend a reimbursement methodology based on a calculation of our true cost (including clinician time, administrative cost, overhead, etc.) + 20%. If you have to rely on a supplier invoice, we recommend reimbursement at invoice + 70% for all orthotic and prosthetic codes. Please see attached spreadsheet. We are happy to discuss these items with you and have marked

the calendar for the first public hearing on March 21st. Please let us know if there is anything additional you need.

Link to feedback

Jim Melancon
Aveanna Healthcare

On behalf of Aveanna Healthcare and our Medical Solutions division, we support the recommendation of the MPRRAC regarding enteral nutrition therapy formula rates and urge HCPF to adopt the recommendation.

Laboratory and Pathology Services

Dr. Patrick Long
Sequence MD

I will be speaking on the Critical aspects of Genetic Testing, specifically Whole Genome (81425/81426) and the addition of coding for whole exome (81425/81426) with focus on the population of CO, the recent AAP guidelines and diagnosis implications.

Whitney Glover
GeneDx

Providing comment on Laboratory and Pathology Services, specifically exome and genome sequencing (CPT 81415, 81416, 81417, 81425, 81426, 81427). Exome and genome sequencing are standard of care for diagnosing complex pediatric rare disease. Clear coverage and reimbursement are critical to ensure access to these guideline supported services.

Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy (PT/ OT/ ST)

Carrie Eckenhoff
Altius Physical Therapy & Wellness

I will not be able to attend this meeting but would like to learn about how PT reimbursement may be affected in the near or distant future.

We are Medicaid providers of outpatient physical therapy. Currently it is working well for us although the PAR process is an administrative burden. If rates drop > 8% beyond current levels it will be unsustainable for us to continue in this capacity.

I am not sure what feedback you are looking for for the meeting but I wanted to provide this if it's helpful.

Ellen Jensby
Alliance

- Make no change to "Pediatric Comprehensive Care Package" (T1026+TL), currently 101.60% of the benchmark, but only based on two other states (Missouri and North Carolina)
- Increase the following EI therapy codes to 100% of the benchmark:
    - Therapeutic Activities (97530, currently at 97.80%)
    - Sensory Integration (97533, currently at 91.10%)
    - Oral Function Therapy (92526, currently at 86.60%)
- Restructure or significantly increase:
    - Speech/Hearing Therapy (92507, currently at 93.40%) to better attract SLPs
- Make no change to:
    - Therapeutic Exercises (97110, currently at 108.80%)

Jessi Hogan
Summit Speech Therapy

Thank you so much for taking the time to meet with me last week and for your patience with my response. I will speak for all the SLP's in the state and say THANK YOU for your inquiry into helping us gain increased reimbursement for the important work that we do by utilizing all possible avenues.

Regarding speech language pathology codes that are considered preventative in nature - please see below for a list of our most commonly used codes and a brief description for each. I have broken the codes up into two different areas, evaluation codes (92523, 92610, 92607) and treatment codes (92507, 92508, 92609, 92526).

We view our evaluations as preventative tools in which we are able to identify deficits early, determine appropriate interventions, and provide recommendations that reduce or eliminate the risk of further functional decline, medical complications, and costly
interventions. The evaluations serve as the gateway to targeted, evidence-based therapy, caregiver training, and compensatory strategies. Similar to our OT and PT counterparts, speech-language pathology is not a modality, but a comprehensive approach to prevent and manage conditions. Our treatment codes are used to not only rehabilitate deficits but actively prevent further decline in communication, cognitive, and swallowing abilities. Early and ongoing intervention leverages neuroplasticity to improve deficits, teaches compensatory strategies to the patients and caregivers and promotes functional independence. By mitigating decline and complications through therapy, these services reduce reliance on costly interventions such as hospitalizations, surgeries, long-term care, and high-cost durable medical equipment, such as feeding tubes.

CPT 92523 – Evaluation of Speech Sound Production with Evaluation of Language Comprehension and Expression

- Identifies early deficits in speech and language that, if untreated, can contribute to academic failure, social isolation, and mental health concerns — all of which lead to increased educational and healthcare costs.
- Prevents escalation of communication disorders that could otherwise result in the need for long-term special education services or institutional placement.
- Guides early intervention strategies that harness neuroplasticity and optimize developmental outcomes.

- Prevents frustration-related behavioral issues, which can lead to additional assessments, interventions, and healthcare use.
- Ensures that comorbid issues (e.g., cognitive, auditory processing deficits) are identified early, preventing compounding impairments.

CPT 92610 – Evaluation of Oral and Pharyngeal Swallowing Function

- Detects swallowing dysfunction before significant complications occur, such as aspiration pneumonia, malnutrition, dehydration, or respiratory failure — all of which drive up healthcare costs through hospitalization, surgery, and long-term care.
- Allows for early implementation of safe feeding techniques, dietary modifications, and therapeutic interventions to reduce the risk of choking, aspiration, and associated medical events.
- Prevents unnecessary progression to more invasive and costly interventions (e.g., feeding tube placement) by guiding timely, evidence-based therapy.
- Reduces emergency room visits and hospital admissions for food or liquid aspiration and related pulmonary complications.

CPT 92607 – Evaluation for Prescription for Speech-Generating Augmentative and Alternative Communication Device

- Prevents communication isolation in individuals with severe expressive deficits, which can contribute to frustration, behavioral challenges, mental health decline, and increased reliance on costly personal assistance or institutional care.
- Ensures timely and appropriate device selection to minimize trial-and-error costs, reduce abandonment of technology, and support effective communication.
- Facilitates continued participation in medical decision-making, reducing risk for medical errors, inappropriate care decisions, and adverse outcomes.
- Promotes patient safety and autonomy by ensuring reliable communication means, reducing reliance on high-cost supports like full-time aides or unnecessary emergency medical interventions.
- When conducted early, prevents secondary effects of prolonged communication deprivation, such as learned helplessness and social withdrawal.

CPT 92507 – Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder

- Prevents deterioration in communication and cognitive function, especially in progressive or chronic conditions (e.g., Parkinson's, ALS, dementia, stroke).
- Reduces long-term costs by delaying or preventing the need for augmentative communication devices, intensive caregiver support, or institutional care.
- Supports neuroplasticity through targeted exercises, helping individuals retain and strengthen communication pathways.
- Home exercise programs and caregiver training enhance carryover and reduce dependence on ongoing therapy.

CPT 92508 – Group Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder

- Provides opportunities for social communication practice, reducing isolation and mental health decline (e.g., depression, anxiety), which are linked to increased healthcare utilization.
- Facilitates peer support, promoting adherence to therapeutic strategies and home programs.
- Prevents regression in functional communication skills by maintaining active use of speech and language in real-life settings.
- Helps slow decline in cognitive-communication abilities through structured, interactive tasks.

CPT 92609 – Therapeutic Services for the Use of Speech-Generating Device (SGD)

- Prevents loss of functional communication in individuals with severe speech impairments, reducing frustration, behavioral issues, and secondary mental health concerns.
- Supports consistent communication to reduce medical errors, improve safety, and promote participation in care decisions.
- Reduces cost burden by preventing unnecessary hospitalizations related to communication breakdowns.
- Ensures optimal use of technology to minimize the need for higher-cost assistive devices or additional caregiver assistance.
- Provides early intervention with SGDs, preventing withdrawal from social interaction and community engagement.

CPT 92526 – Treatment of Swallowing Dysfunction and/or Oral Function for Feeding

- Prevents progression of dysphagia, reducing the risk of aspiration pneumonia, malnutrition, dehydration, and hospital admissions.

- Reduces need for expensive interventions like gastrostomy (feeding) tubes, associated surgeries, and long-term tube feeding supplies.
- Decreases cost of special diets and modified foods by improving or maintaining safe oral intake.
- Improves feeding efficiency, lowering caregiver burden and associated indirect costs.
- Early intervention can eliminate or delay the need for enteral feeding and prevent secondary complications (e.g., gastrointestinal distress, respiratory infections).

Thank you again for your time, we truly appreciate the work you and the committee are doing. Please don't hesitate to reach out with any more questions you may have.

American Speech-Language-Hearing Association

Link to feedback

Chris Edmundson
American Physical Therapy Association

APTA would like to go on record stating that we believe that the exclusion of exercise codes as a preventative treatment option is a big oversight of the MPRRAC.

XXXXX

My XXX age XXX, has been on Medicaid due to being on the CES waiver. XXX has profound autism, is nonverbal, incontinent, no sense of safety, high threshold for pain, minimal body awareness, with significant behaviors including SIBs, which is Self Injurious Behavior. XXX also has PICA, which is an eating disorder where XXX eats non food items. XXX also is a compulsive eater, and will eat until XXX vomits, unless supervised. XXX also needs supervision while eating so that XXX doesn't choke on XXX food, that must be cut up into bite size pieces. So, 24/7 supervision is required.

XXX goes to a special school for autism and has anywhere from one to one supervision, to sometimes two to one on tougher days. If you can imagine, therapy is a big part of XXX life. Without the therapy services we get through Medicaid we would have been

lost. As XXX, I stay home with XXX, bringing XXX to and from school, maintaining XXX therapy schedules, doctor visits, food preparation, and overall supervision. XXX was one of the students on the L-76 school bus with the para that was charged with 13 counts of abuse in the LPS school district one year ago, so driving XXX myself is the only option. This leaves me with barely 5 hours a day that I am not supervising XXX.

Most nights XXX doesn't sleep more than 2-4 hours, which means my sleep is constantly disrupted. I love XXX very much, XXX will be moving to an adult waiver on XXXX. We will lose many services for XXX, which is sad because XXX thrives with these services. XXX is learning life skills, things that come so normal to any neurological individual, but is extremely challenging for XXX. XXX needs guidance and assistance with every aspect of her XXX.

XXX uses an electronic communication device we lovingly refer to as "XXX talker". XXX is in speech therapy to help XXX learn many forms of communication since XXX has no spoken word.

XXX is in aquatic therapy due to XXX lack of safety with water. XXX is slowly learning how to float, which is a life saving skill. Without aquatic therapy XXX would have no safety awareness and if you look at the statistics, water related death is one of the number one causes of death for people with autism. XXX also receives hippotherapy and OT.

Therapists provide life altering skills for individuals. Giving them a chance of possibly finding some sort of independence, feeling self worth, being proud of accomplishments, and finding their place in an unforgiving society.

Please do not take away these services. XXX is just one in thousands that need these services to thrive.

XXXXX

Dear Department of Health Care Policy & Financing,

I am XXX in the community that receives Outpatient PT, OT, SLP for XXX. XXX has an ultra rare genetic condition, DeSanto-Shinawi Syndrome. And the therapies XXX has received has been life changing for XXX. I am writing today to request and advocate that you do NOT cut rates for the services XXX receives. These services have given XXX the ability to progress in mobility, gross/fine motor, and speech challenges that make XXX life much harder day-to-day. XXX therapy providers show up daily with passion, vigor, and knowledge in improving XXX life. Cutting these services could

cause many of his providers, including but not limited to, XXXX, to go out of business. And these children that have such specialized and high needs would be left without medically necessary services. And that would be truly detrimental for them. Thank you.

XXXXX

Dear Department of Health Care Policy & Financing,

I am XXX advocate in the community XXXX receives Outpatient PT, OT, SLP, Durable Medical Equipment and Orthotics. I am writing today to request and advocate that you do NOT cut rates for the services XXX receives. These services are important for XXX and without these services they would decline in function, struggle exponentially, or even have to be hospitalized. These services offer XXX to have mobility, autonomy, and have the chance to play a role in society. Please do not cut rates for Outpatient PT, OT, SLP, Durable Medical Equipment/Prosthetics or Orthotics. Cutting these services could cause my current provider, XXX, to go out of business, then XXX would be left without medically necessary services. Thank you.

XXXXX

Thank you for the opportunity to submit a written comment regarding Medicaid provider Rates, I appreciate an opportunity to give my experience and feedback.

I'm a XXXXXX with severe special needs. We are life long Colorado Residents and XXX has been on a medicaid exception waiver due to XXX disabilities for much of XXX life. We are very thankful for Medicaid, I do not want to think of what XXX life would be like without it. XXX therapies in particular have been very beneficial for XXX. XXX in a wheelchair with limited mobility and extremely tight muscles, and uses a "talker" assistive device to speak. With therapy XXX regularly works on properly stretching spastic inactive muscles, moving to increase blood flow, works on fine motor skills, and learns simple tasks we all take for granted but are very hard for XXX. These are the types of benefits XXX gets that literally extend XXX life and make it possible to participate in this world. XXX has come to trust and listen to XXX OT (XXX) and Speech Therapist (XXX) as friends, so XXX works much better. They are invaluable resources to us.

Due to Medicaid's low reimbursement we've always struggled to get doctors and therapists across the board. Many won't accept Medicaid patients. It's vital that we look out for the ones that will. I would like to advocate in any way I can that we do

not cut the rates for services. These rates are already well below standard, further lowering them would risk them going out of business or not accepting Medicaid patients, both tragic outcomes when it's already a struggle to find the services we need. Therapy services are not large wealth generating businesses, they simply don't have the option to absorb these cuts. Please do not cut rates for OT/PT/SLP. The impact to XXXX losing these services would be substantial to XXX life.

Laura Morgan, Life Wheels On, P.C.
Becky Breaux, Center for Innovative Design and Engineering
Krista Covell-Pierson, Covell Care and Rehabilitation
Cathy Bodine, Center for Innovative Design and Engineering
Jay Manush, Center for Innovative Design and Engineering
Aleaza Goldberg, Center for Innovative Design and Engineering
Claire Simpson, Center for Innovative Design and Engineering
Michelle Lange, Access to Independence, Inc.

To Whom it May Concern,

We are writing to request a reimbursement review for Current Procedural Terminology (CPT) code 97755. Health First Colorado members who require a complex rehabilitation technology evaluation or assessment must receive an initial Assistive Technology Assessment from a licensed speech, physical, or occupational therapist under HB14-1211. Service providers must request a PAR to use procedural code 97755. Under the PAR, members can receive 20 units of 97755 per day and 60 units per year.

As service providers who regularly use the Assistive Technology Assessment PAR for CRT service provision, we regularly bill two hours or more of this code per date of service due to the complexity and time-consuming nature of assistive technology and CRT services. The option to bill for longer visits ensures that we can provide comprehensive person-centered assessments, conduct equipment trials, engage in shared decision-making with the client and equipment supplier, and provide individualized care plans that accommodate the unique health, transportation, and caregiving needs of members.

While the Assistive Technology Assessment PAR accommodates the time-consuming nature of face-to-face services, we spend significant non-billable time during assistive technology and CRT service provision. Non-billable activities can include the following:

- collaborating with physicians, case managers, or other healthcare providers

- coordinating services for equipment trials and fit/deliveries
- acquiring and setting up equipment in preparation for trials and training
- writing detailed and lengthy letters of medical necessity
- preparing funding packets
- researching technology options and costs
- communicating with payors
- responding to pended requests and denials

As a result, service providers in this area regularly spend significant time on non-billable tasks, which threatens the sustainability of these services. These problems are not unique to our organizations. Below is a summary of recent studies from the field:

1. **Productivity rates at Shirley Ryan Ability lab in Chicago**
   An internal productivity assessment at the Rehabilitation Institute of Chicago (now the Shirley Ryan Ability Lab) found that therapist productivity in a seating clinic was typically 25–30% lower than in a standard outpatient rehab setting. This was in part due to the time-intensive nature of wheelchair assessments, equipment trials, fittings, and required follow-up documentation and coordination, much of which is non-billable yet essential for ethical, person-centered, and effective care. The author concluded that these non-billable expenses contributed to the closure of another seating clinic in Chicago and reduced access to care.
   Citation: Pedersen JP, Harmon D, Kirschner KL. Is an appropriate wheelchair becoming out of reach? PM R. 2014;6(7):643–649. doi:10.1016/j.pmrj.2014.06.001. PMID: 25059898
2. **Reimbursement for services at the University of Pittsburgh CRT Clinic**
   A study presented at the 2025 International Seating Symposium reported that an average power wheelchair evaluation included 83 minutes of billable time and 64 minutes of non-billable time. The non-billable tasks—such as detailed documentation for letters of medical necessity (LMNs), coordinating with multiple parties, and managing order status—are integral to delivering medically necessary CRT services and ensuring proper follow-up. The study concluded that current reimbursement does not cover the costs of clinician salaries (relative to average salaries in the region), let alone clinic operating costs.
   Citation: Pacheco Busquets M, Morrow C, Schein R, Schmeler M. Maintaining productivity standards in a seating and mobility clinic: Documenting all clinician tasks [Conference session]. International Seating Symposium; March 2024; Pittsburgh, PA.

3. **Workload analysis for AT Services at the University of Illinois Chicago (UIC)**
   In this study, researchers conducted an 18-month survey with occupational and speech therapists providing Augmentative and Alternative Communication assessments and training at the Assistive Technology Unit at UIC. Analysis revealed that clinicians spent 56.3% of their time on non-billable tasks. After accounting for non-billable time, their reimbursement averaged $10.56 per hour. Researchers questioned the sustainability of providing these services as a result.
   Citation: Bay et al., 2025. Workload analysis for AT services: a program evaluation. Poster presentation. ATIA, January 29-31st, 2025, Orlando Florida
4. **Reimbursement for services at a specialized seating and wheeled mobility clinic in Colorado**
   An ethnographic study published in 2024 found that clinicians at an outpatient seating and wheeled mobility clinic in Colorado reported spending 35-50% of their time on non-billable tasks and experienced insufficient reimbursement for face-to-face services. Health First Colorado members at the study site regularly received services under an Assistive Technology Assessment PAR. Nevertheless, the clinic received insufficient funding to cover operational costs. To offset financial losses, the organization supplemented their income through annual fundraising events and grant awards. This research also included interview data with clinicians in Colorado and other U.S states who reported similarly high non-billable workloads and a tendency for well-respected seating and wheeled mobility clinics in the U.S. to go out of business over the past decade.
   Citation: Breaux, R. D. (2024). Person-centered care or payer-centered care? An ethnographic study of an outpatient seating and wheeled mobility clinic (Order No. 31633473). Available from Dissertations & Theses @ University of Colorado at Denver; Dissertations & Theses @ University of Colorado System; ProQuest Dissertations & Theses A&I. (3143168198). Retrieved from https://aurarialibrary.idm.oclc.org/login?url=https://www.proquest.com/dissertations-theses/em-person-centered-care-payer-ethnographic-study/docview/3143168198/se-2

Summary:
These findings demonstrate that clinicians delivering assistive technology and CRT services incur substantial non-billable workload and operational costs not captured in current reimbursement levels. Without adjustment, the current structure disincentivizes providers from offering these essential services, thereby threatening access to appropriate technology for individuals with complex disabilities.

Given these problems, we respectfully ask the committee to consider a reimbursement increase in this area. The current HCPF reimbursement rates for commonly billed OT, PT, and ST clinical codes are as follows:

- 97530 – Therapeutic Activity: $34.97
- 97110 – Therapeutic Exercise: $32.14
- 97140 – Manual Therapy: $29.98
- 92609 – Untimed ST code for AAC Treatment: $92.36 (Sessions typically last 60-90 minutes).

We recommend that HCPF increase reimbursement as follows:

- CPT 97755 – Assistive Technology Assessment by at least 30% above the current rate for CPT 97530 (Therapeutic Activity), which is currently reimbursed at $34.97. Thus it would be reimbursed at $45.46 or more.
- Consider reimbursement for non-billable time, such as a maximum of one hour per client.

These requests are based on both peer-reviewed research and current clinic operations data that highlight the significantly higher complexity, time investment, and non-billable workload associated with CRT-related evaluations and interventions. These changes would help offset the disparity in clinician effort, ensure continued access to CRT services in Colorado, and promote sustainability in specialized assistive technology and wheelchair clinics.

Thank you for your consideration of this request. We welcome the opportunity to provide additional data or collaborate in any review processes that support equitable and evidence-based reimbursement for these specialty services.

Kim Ramey

Unfortunately I wasn't able to attend the meeting today but would love to get some follow-up information about what was discussed as far as the rates.

I am a physical therapist working with early intervention and struggle with the current rates and if they go down it's going to be even more difficult. I work in a rural community and a lot of our time is spent driving from one family to another and we are not getting reimbursed for mileage either. In addition to living in a rural community if I don't drive to see these families and clients they have almost zero

resources to seek outpatient Pediatric Therapy and many of the families don't have access or ability to drive down to Denver for further services.

Thanks in advance for your consideration and attention to my email. I'll be anxiously awaiting information and feedback.

American Physical Therapy Association

The Profession of Physical Therapy

Physical therapy (PT) is a vital healthcare profession dedicated to improving mobility, function, and quality of life through evidence-based care. Physical therapists (PTs) are movement experts who optimize physical abilities, prevent injuries, and address chronic pain or limitations caused by illness, injury, or surgery. PTs conduct comprehensive evaluations that integrate a review of the patient's health history, medications, and overall medical condition. This includes a review of all body systems and a physical examination including assessments of neurologic, cardiopulmonary and musculoskeletal function. This may include testing of reflexes, strength, range of motion, balance, posture, functional movement patterns and more. Treatment plans incorporate therapeutic exercise, manual therapy, patient education, neuromuscular re-education, functional retraining, pain management techniques, and other thermal and electrotherapeutic modalities to support healing and enhance patient outcomes.

- Educational Requirements:
    - PTs are required to earn a Doctor of Physical Therapy (DPT) degree from an accredited program, typically a three-year post-graduate program combining rigorous coursework with extensive clinical training.
- Licensing and Specialization:
    - PTs must pass the National Physical Therapy Examination (NPTE) to obtain licensure. Many pursue advanced certifications in areas such as sports rehabilitation, orthopedics, pediatrics, geriatrics, genitourinary and reproductive health..

The Value of Physical Therapy

- Improving Patient Outcomes and Quality of Life:
    - PTs empower patients to regain mobility, manage chronic conditions, and recover from injuries or surgeries.
    - Early physical therapy intervention reduces pain, prevents complications, and avoids more invasive and costly treatments like surgery or opioid use.

- Reducing Healthcare Costs:
    - Numerous peer reviewed studies demonstrate that access to physical therapy leads to reduced total healthcare expenditures.
- Early physical therapy reduces opioid prescriptions by 89% and unnecessary imaging or surgeries by 28%.
- Total medical costs for an episode of low back pain care were $2726.23 lower for patients receiving early physical therapy.
- According to data from Optum, referral to physical therapy within the first 2 weeks of injury are critical for controlling overall healthcare costs.
- Preventative care and rehabilitation provided by PTs lead to significant savings for payers, including Medicaid, by addressing issues before they escalate.
- Workforce Contributions:
    - PTs help injured workers return to their jobs faster, reducing lost work time and increasing productivity.

Challenges Faced by the Physical Therapy Profession

Despite the immense value that PTs provide, the profession faces significant financial and systemic challenges, particularly related to the burden of educational debt and low payment rates, including Medicaid. Disproportionate Educational Debt Burden Studies published in BMC Medical Education and Physical Therapy Education illustrate the disproportionate impact of educational debt on PTs:

- PTs face one of the highest debt-to-income (DTI) ratios in healthcare, ranging from 157% to197%, compared to
    - Primary care physicians: 110%
    - Nurse practitioners: 92%-117%
    - Physician assistants: 93%-104%
- The elevated DTI ratio is due to:
    - High tuition costs for DPT programs.
    - Relatively lower median salaries compared to other doctorate-level healthcare providers.
- Unlike physicians and other advanced practitioners, PTs have fewer loan forgiveness opportunities, making repayment significantly more challenging.

Workforce Sustainability Issues

- Declining Enrollment and Reduced Availability:
    - The rising cost of DPT education discourages students, especially those from lower socioeconomic backgrounds, from pursuing careers in physical therapy.
    - Workforce shortages result as fewer students enter the profession, and financial strain forces some PTs to leave the field.

    - Many of the PTs who remain in the field choose to work for practices that are not in network with insurance, Medicare or Medicaid to attain higher salaries.
- Geographic and Specialty Imbalances:
    - PTs with high debt are less likely to work in rural or underserved areas where salaries are often lower, exacerbating healthcare disparities.
    - High debt also deters PTs from pursuing specialties like geriatrics or pediatrics, which offer lower compensation but are vital for patient care.
- Burnout and Job Dissatisfaction:
    - The stress of managing high debt contributes to burnout, further exacerbating workforce shortages.

The Case for Increasing Medicaid Payment Rates in Colorado

- Low Payment Challenges:
    - Medicaid payment rates for physical therapy services in Colorado are often below the cost of providing care.
    - These low rates discourage PT practices from accepting Medicaid patients, limiting access to care for low-income populations.
    - These payment rates lead to lower salaries for PTs working in practices that accept Medicaid and other insurances. The result is a decline in businesses that are willing to accept Medicaid and other insurance with more PTs choosing to work for practices that do not accept Medicaid.
- Justification from HCPF Documents:
    - The HCPF Regional Health Equity Plan FY23-24 and the HCPF Performance Plan emphasize:
        - Improving Access to Care: We know that only 6-10% of patients who are appropriate for physical therapy are able to access our services. The need to eliminate barriers to care in underserved and rural areas aligns with increasing Medicaid payment rates, which would encourage more PTs to serve Medicaid populations.
            - Enhancing Maternal and Child Health Outcomes: Physical therapists play a pivotal role in managing prenatal and postpartum health, including alleviating pregnancy-related pain, improving pelvic health, and supporting postpartum recovery. These interventions align with HCPF's health equity goals to reduce disparities and improve outcomes for vulnerable populations.
    - Reducing Long-Term Healthcare Costs: By addressing musculoskeletal issues early, PTs prevent complications that would otherwise require

costly interventions. PT reduces total healthcare costs by preventing hospitalizations, surgeries and long-term opioid prescriptions. This cost-saving strategy supports HCPF's objective of reducing total healthcare expenditures.

- Improving Financial Viability:
    - Increasing Medicaid payment rates would help offset the financial strain on PT practices, enabling them to remain in network and serve Medicaid patients without incurring losses.
- Sustaining the Workforce:
    - Higher payment rates would encourage PTs to remain in the profession and provide care in underserved and rural areas, addressing geographic imbalances.

CPT Codes Relevant to the PT Profession

- Most commonly used codes in bold

29580	29581	29584	90901	90912	90913	95851
95852	95885	95886	95887	95992	97012	97014
97016	97032	97035	**97110**	**97112**	97113	**97116**
97124	**97140**	97150	**97161**	**97162**	**97163**	**97164**
97530	97535	97550	97551	97552	97597	97598
97602	97605	97606	97750	97760	97761	97762
97763	98960	98961	98962	98975	98976	98977
98980	98981	G0283	**20560**	**20561**		

Comparison States

- Cost of Living Index
    - Colorado - 98.4
    - Alaska 104.9 - Moderately higher than CO
    - New Mexico - 94.8 - Moderately lower than CO
    - North Dakota - 97.3 - Similar to CO
    - Arizona - 98.6 - Similar to CO
    - Texas- 91.5- Moderately lower than CO
- Demographics

    - Colorado shares some demographic similarities with Texas, Arizona, North Dakota, Alaska, and New Mexico—such as youthful populations in some cases and diverse racial compositions in others.
    - An important similarity between CO, NM, TX and AZ is that they have large urban centers along with significant portions of the population residing in rural areas. This dichotomy creates considerable challenges for physical therapy practices to provide monetary incentives for physical therapists to work in rural areas.
- Medicaid payment rates - The following list are states with Medicaid payment rates that the American Physical Therapy Association believes are appropriate for comparison with Colorado
    - Alaska - These payment rates would provide Colorado providers with good payment rates that would allow us to sustain a healthy workforce and meet the needs of Coloradans for many years to come.
    - New Mexico - NM has higher payment rates than Colorado despite a lower cost of living. These payment rates would provide fair payment that would likely allow practices to provide fair salaries to providers, retain this critical workforce and serve more Coloradans to help drive down total healthcare costs.
    - North Dakota- These payment rates are higher than CO despite having a similar cost of living. Even still, we believe these payment rates are not sustainable for CO and will lead to challenges retaining businesses and providers willing to accept Medicaid in the coming years.
    - Arizona - These payment rates are also very similar to CO with a similar cost of living. We believe these payment rates are not sustainable for CO and will lead to challenges retaining businesses and providers willing to accept Medicaid in the coming years.
    - Texas - In spite of the much lower cost of living, the payment rates for 97161, 97162, 97163 and 97164 are much more appropriate than that of Colorado. Making this change alone would add much resilience to the workforce in CO. We do not believe that the entirety of the TX fee schedule is an appropriate comparison.

Summary and Recommendations

Physical therapy is an essential health profession that improves patient outcomes, reduces healthcare costs, and enhances quality of life. However, the challenges posed by high educational debt and low payment rates jeopardize its sustainability. Increasing Medicaid payment rates for physical therapists in Colorado is essential to:

- Meet HCPF's performance goals
- Ensure access to high-quality care for patients with Medicaid.

- Support PTs in managing their educational debt and continuing to provide care.
- Reduce long-term healthcare costs by promoting physical therapy as a first-line treatment.

Investing in the physical therapy profession is not only an equitable solution for providers but also A cost-effective measure to improve health outcomes and reduce disparities for Coloradans. The American Physical Therapy Association recommends an increase in payment rates of 10% for all physical therapy codes.

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Occupational Therapy Association of Colorado

Report: Benchmarking and Medicaid Reimbursement for Occupational Therapy in Colorado

Introduction

The importance of occupational therapy (OT) in healthcare cannot be overstated, as it helps individuals regain independence, manage chronic conditions, and recover from injuries. Occupational therapists (OTs) and occupational therapy assistants (OTAs) work in a variety of settings, providing essential care that supports independent living and enhances mental and physical health. OT interventions reduce barriers to daily activities, improve client outcomes, and help prevent more costly medical interventions. With the increasing demand for OT services, it is crucial to evaluate Medicaid reimbursement rates and workforce sustainability. This report aims to provide a comparative analysis of Medicaid reimbursement in Colorado, benchmarking it against other states with similar demographics and healthcare challenges. Additionally, this report discusses OT practices, the financial challenges faced by OT providers, and the implications of payment rates on access to care.

Comparison of States for Benchmarking

Colorado's Medicaid payment structure is an important consideration when assessing the sustainability of its OT workforce and the broader impact on healthcare delivery. To benchmark Colorado's OT Medicaid reimbursement rates, it is necessary to compare with states that face similar challenges, including operating with both urban and rural service areas, diverse populations, and the need for quality OT services. States such as Alaska, New Mexico, North Dakota, and Texas provide useful comparisons due to their similar demographics and geographic considerations.

1. **Alaska** offers Medicaid reimbursement rates that are higher than Colorado's, which helps sustain a workforce and meet healthcare demands in rural areas.
2. **Arizona**'s rates are similar to Colorado's but are seen as unsustainable, particularly for retaining OT providers long term.
3. **New Mexico and North Dakota** provide Medicaid reimbursement rates that are higher than Colorado's, despite having a lower cost of living, which supports workforce retention.
4. **Texas**, despite its lower cost of living, provides better reimbursement rates for key therapy codes, which may offer useful insights for Colorado if similar adjustments were made.

CPT Codes

95851	95852	96110	96112	96113	96125	96127	97010
97018	97022	97035	97042	97110	97112	97113	97116
97124	97129	97130	97139	97140	97150	97165	97166
97167	97168	97530	97533	97535	97537	97542	97545
97546	97550	97551	97552	97750	97755		

Occupational Therapy in Colorado

OT is a critical component of healthcare in Colorado, supporting individuals with physical, cognitive, and mental health challenges. It contributes significantly to reducing healthcare costs by promoting early intervention and managing chronic diseases. However, OT providers face significant financial challenges, particularly related to Medicaid reimbursement rates.

According to a 2025 survey conducted by the Occupational Therapy Association of Colorado (OTAC), many providers have experienced substantial changes in their practices due to payment cuts in the past two years. Some respondents reported reduced purchasing of clinical tools or an expanded range of services as employers adjusted to these financial constraints. Furthermore, increased productivity requirements were noted by some, while a few participants also reported wage stagnation. Despite these challenges, the majority of survey respondents accept various Medicaid plans, including Health Colorado Inc. and CHP+. However, issues such as prior authorization delays, visit limits, and insufficient reimbursement were frequently reported. For instance, 33% of respondents noted challenges with prior authorizations, and 50% mentioned visit limits. These challenges have led to a backlog in services, with 53% of respondents maintaining a waitlist for Medicaid patients, and 66% of those reporting wait times of 1-3 months.

Challenges in Provider Participation and Workforce Sustainability

The OTAC survey data reveals significant barriers to participation in certain insurance plans, particularly Medicaid. These include low reimbursement rates, administrative burdens, and exclusions based on practice models, such as mobile outpatient services being excluded from major insurers. Survey participants also reported challenges with specific insurance plans like CHP+ and Cigna, which posed difficulties in negotiating reimbursement rates and meeting administrative requirements.

A major concern expressed by providers was the sustainability of their practices under current Medicaid payment structures. Many of them indicated that despite a lower cost of living in Colorado compared to other states, the payment rates were insufficient to maintain a viable practice. For example, mobile outpatient services, which provide essential care in rural or underserved urban areas, faced exclusions from some of the major insurers, further limiting access to care for vulnerable populations.

Debt-to-Income Ratio and Financial Pressures

The financial pressure on healthcare professionals, including occupational therapists, is another critical factor that affects workforce retention and service delivery. A 2023 report from SoFi revealed that health professionals, including OTs, carry significant student loan debt. The report highlighted that OTs rank 14th in terms of student debt among healthcare professionals, with high student loan balances impacting their ability to sustain a work-life balance and make financial decisions. This issue is exacerbated by the low reimbursement rates offered by Medicaid and other insurers, making it more difficult for providers to absorb these financial burdens.

Conclusion and Recommendations

The findings from the OTAC survey and the comparison of Medicaid reimbursement rates in other states suggest that Colorado's Medicaid provider rates for OT services are insufficient to sustain a growing and diverse workforce. Increasing Medicaid reimbursement rates by 10% would be an important step toward improving the financial viability of OT practices and expanding access to care, especially in rural and underserved areas. Such an increase would align with Colorado's broader healthcare goals, including improving health outcomes, reducing healthcare disparities, and promoting equitable access to rehabilitative care.

Investing in OT services, particularly by adjusting Medicaid payment rates, would not only benefit healthcare providers but also help reduce long-term healthcare costs by preventing complications and reducing hospitalizations. Higher reimbursement rates would also support the recruitment and retention of qualified OT providers, ensuring that Coloradans have access to the services they need to maintain health and independence.

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Molly Hahn-Floyd
Occupational Therapy Association of Colorado

We didn't receive a direct request from HCPF regarding preventative codes, but APTA Colorado and CSHA let us know that you're seeking this information. As with physical and speech therapy, occupational therapy (OT) includes several codes that represent preventative care. OT practitioners are uniquely qualified to modify daily activities and environments to enhance safety, promote independence, and prevent health complications that often lead to higher healthcare costs.
For example:

- Supporting a client in modifying their bathroom to reduce the risk of falls, injury, and hospitalization.
- Properly assessing and fitting an individual to their wheelchair to reduce the risk of pressure ulcers and improve long-term mobility and skin integrity.

Below is a breakdown of occupational therapy codes that reflect preventative care and risk reduction:

Occupational Therapy Evaluations
OT evaluations are foundational for identifying functional limitations, assessing safety risks, and developing proactive intervention plans. They help prevent complications by identifying impairments early and promoting independence in daily living.

- 97165 – Occupational therapy evaluation, low complexity
  Includes a brief history, 1-3 performance deficits, and a straightforward clinical decision-making process.
- 97166 – Occupational therapy evaluation, moderate complexity
  Includes an expanded review of history, 3-5 performance deficits, and moderate clinical decision-making.
- 97167 – Occupational therapy evaluation, high complexity
  Comprehensive review of medical and therapy history, more than 5 performance deficits, and complex decision-making.
- 97168 – Re-evaluation of occupational therapy

Used when there is a documented change in functional status or a need to update the plan of care.

Therapeutic Interventions

These codes represent services that help individuals maintain independence, reduce the likelihood of injury, and prevent hospitalizations or institutional care.

- 97129 – Therapeutic interventions targeting cognitive functions such as attention, memory, reasoning, and problem-solving; includes compensatory strategies to support daily function.
- 97530 – Therapeutic activities using dynamic movements to improve functional performance in real-life tasks.
- 97533 – Sensory integrative techniques to enhance the brain's ability to process sensory input and produce appropriate responses to the environment.
- 97535 – Training in self-care and home management tasks such as ADLs, safety, use of adaptive equipment, and meal preparation.
- 97537 – Community and work reintegration training including transportation, money management, shopping, and vocational activities.
- 97542 – Wheelchair management including assessment, fitting, training, and education to reduce secondary complications such as pressure injuries.
- 97545 – Initial two hours of work hardening/conditioning to prepare individuals for return to work and prevent re-injury.
- 97546 – Each additional hour of work hardening/conditioning (billed in conjunction with 97545).

Caregiver Training

Educating caregivers plays a critical role in reducing complications and promoting safe and effective care at home.

- 97550 – Individual caregiver training to support a patient's ADLs, safety, communication, and mobility needs (initial 30 minutes).
- 97551 – Each additional 15 minutes of individual caregiver training.
- 97552 – Group caregiver training provided face-to-face with multiple caregivers, focusing on improving patient care and reducing risks.
- G0543 – Group caregiver training for individuals with chronic conditions, focusing on direct care strategies to prevent complications like pressure ulcers and infections.

Modalities

These are physical agent modalities used to reduce pain, promote healing, and improve movement—supporting long-term function and independence.

- 97010 – Application of hot or cold packs to reduce inflammation or pain.

- 97018 – Use of paraffin baths to relieve joint stiffness and pain.
- 97022 – Whirlpool treatments to improve circulation and soft tissue mobility.
- 97024 – Diathermy (e.g., microwave), to deliver deep heat for muscle relaxation and tissue healing.
- G0281 – Electrical stimulation specifically for wound care to promote healing.
- G0283 – Unattended electrical stimulation for non-wound care therapeutic goals.
- G0329 – Electromagnetic therapy for chronic ulcers (Stage III and IV) not responding to standard care, supporting prevention of further deterioration.

Next Steps & Follow-Up
Please feel free to reach out with any questions. You can reach me (Molly Hahn-Floyd) directly at 719-210-3737 or email Heidi Kunugi at heidikunugi@gmail.com.
We also heard that occupational therapy will be discussed during the upcoming rate review meeting on Friday, July 18. Would it be helpful for us to attend that meeting? If so, will you share what topics will be covered and if there's anything else we can provide ahead of time beyond the information above? Thank you for your time and support, and we look forward to continuing this conversation.

Molly Hahn-Floyd
Occupational Therapy Association of Colorado

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Lauren Preston
Pediatric Therapy of Colorado

Pediatric occupational therapy is the definition of preventative care by supporting early development, identifying delays, and promoting functional independence. Through early intervention, occupational therapists help children build essential skills for daily living, learning, and social participation. By addressing sensory processing, motor skills, and self-regulation early on, OT reduces the risk of academic struggles, behavioral issues, and long-term disability. Pediatric OT a vital component of early and proactive healthcare. Medicaid is a large part of this and helps millions of children each day.

Early intervention occupational therapy for children can significantly reduce overall healthcare costs by addressing developmental delays before they escalate into more complex, costly issues. By promoting functional skills, reducing the need for specialized services, OT not only supports healthier outcomes but also decreases the long-term economic burden on healthcare, educational, and social systems.

It would be a disservice to not invest in further generations and by doing this increase overall healthcare costs long-term. I implore you and your colleagues to act in accordance with the society we aspire to; one that supports those in need, building them up to their full potential to contribute to their communities — not see them as the weakest links, most readily disregardable when budgets are tight.

Katy Owens, Acute Care Occupational Therapist

I am an occupational therapist in Colorado. I work for UCHealth, and I also own a private practice that specializes in chronic pain. A few years ago, Colorado passed a bill that mandates 6 visits with an OT for any patients that may be prescribed an opioid. I depend on this law and access to Medicaid to see patients in my private practice. Cutting Medicaid would be devastating to me personally, as well as my patients.

Beyond myself, I know other private practice practitioners who would be absolutely devastated by significant cuts to Medicaid.

I understand that balancing a budget is complex and multifaceted. But in this current political climate, with threats of Medicaid at the national level, consider the gravity of Colorado maintaining Medicaid benefits.

Holly Ross
Community Aquatics n' Occupational Engagement

Dear Department of Health Care Policy & Financing,

I am a small business owner in the state of Colorado that takes Medicaid and provides outpatient OT services. More specifically I specialize in aquatic therapy and drowning prevention for those with disabilities. Currently, I am the only provider in the state that can perform these services together because of my specialized training. I have actively looked for another provider like me and have not found one that accepts Medicaid. With 19 clients on the waitlist, I am actively hiring, training providers, and helping more patients in the community. If outpatient OT rates were to be cut, I will lose providers that work for me, and subsequently those clients will lose services and have nowhere to go. I could even go out of business and there would be no way for these families to get services. I also run free disability events for families & children with disabilities with resource fairs that allow families to access the community and navigate services to fit their needs. My company has been in business for 5 years and we are a vital sector for outpatient OT services. If cuts happen and my company goes out of business, those with severe disabilities, medical complexities, high behaviors,

and high needs will go without services. Please do not cut Outpatient OT rates. Thank you for your time.

Heather McLaughlin
Rocking Horse Occupational Therapy

I am an occupational therapist, living in Golden, working out of Longmont, specializing in pediatrics . I am writing to express my concern about potential cuts in therapy rates.

I utilize horse movement as a therapy tool to enhance my clients' improvement. While horses tend to be far more therapeutic than a therapy ball, they are also far more expensive to maintain. 94% of my current caseload are Medicaid recipients, all with significant special needs. If these cuts go into effect I will have further difficulty affording this unique intervention. This would result in decreased access to a beneficial intervention for these highly involved clients, many of whom do not tend to respond well to traditional therapies. 2/3 of our barn budget is already being paid for by private and community donations.

I completely understand that Colorado is in an uncomfortable position, needing to make difficult decisions around funding. Please consider, for those of us who work primarily with Medicaid clients, getting a pay cut at this time when everything is becoming increasingly and perhaps exponentially more expensive, will have a bigger negative effect than at other times.

A better solution to saving money might be to better regulate commercial insurances, who are in the business of denying claims for profit. Ensure that they are not wilfully complicating the system so as to ultimately withhold payment, and ensure that their rates are equal to or higher than Medicaid rates.

Thank you for your time and consideration.

Jill Hawks
Alpine Speech Therapy, LLC

Hello, my name is Jill Hawks. I am a speech-language pathologist (SLP) and the owner of a pediatric outpatient private practice in Denver, CO. I also have the honor of serving as the President-Elect for the Colorado Speech and Hearing Association (CSHA) for 2025.

In my practice, I provide speech-language services to children from birth to age 18 in home-based, community-based, and teletherapy settings. I am also a contracted early intervention provider. I am committed to ensuring that all children—regardless of their financial situation—have access to high-quality speech therapy services; which is why I accept Medicaid clients, even though my practice otherwise operates on a private-pay model.

However, the current Medicaid reimbursement rates create significant challenges that make it unsustainable for me, and many other non-clinic-based outpatient providers, to maintain a majority Medicaid caseload. The primary concerns include:

1. As a mobile provider, I drive throughout the Denver metro area. Given the financial constraints of Medicaid reimbursement, I have to be highly selective in accepting new clients based on the areas I already serve. Additionally, Medicaid policies prohibit me from charging a no-show or late cancellation fee. If a client does not show up for a session, I lose up to an hour of billable time, including travel, with no way to recoup those costs.
2. The primary billing code I use, 92507, is untimed, meaning that regardless of the complexity or duration of care required, I receive the same reimbursement rate of $72.01 per session limited to one per day. This structure creates inequities across providers and clinics and often forces me to compensate for the low reimbursement rate by taking on more private-pay clients, limiting my capacity to serve Medicaid beneficiaries.
3. Like all businesses, private practices are impacted by inflation and the increasing costs of operation. As a solo provider, I face mounting expenses while also striving to earn a livable wage in Colorado. Without appropriate reimbursement, maintaining a practice that serves Medicaid clients becomes increasingly difficult.

In summary, increasing Medicaid reimbursement rates would allow outpatient SLPs like myself to:

- Provide equitable and appropriate therapy time under the current untimed code structure.
- Sustainably balance travel demands for home-based and community-based services.
- Mitigate the financial burden of last-minute cancellations and no-shows.

By ensuring adequate reimbursement, we can continue delivering essential speech-language services to clients who need them most. Thank you for your time and support in advocating for fair Medicaid reimbursement rates for outpatient SLPs in Colorado.

Linda Halk
Colorado Speech Language and Hearing Association

Good afternoon members of the Medicaid Rate Review Advisory Committee,

My name is Linda Falk. I am a speech-language pathologist and board member of the Colorado Speech Language and Hearing Association. I work for a critical access hospital in northeastern Colorado. In our organization we serve, acute inpatient, swing beds, extended care patients, and outpatient.

There is limited access to speech therapy services in my area. When I first returned to the area, I was the only medical SLP in a 30-mile radius. Recently, Sterling (30-miles away) lost their SLP, which has created more of a burden to find services. I may now be the only SLP for a 60-mile radius or further.
In my setting I serve patients from the pediatric to geriatric populations with Medicaid. Many of them must drive 40 miles 1-way to receive my speech therapy services. This is a great burden to the family and caregivers. Due to the rural area, weather also plays a factor in being able to attend therapy, leading to cancelations when roads are icy or closed.

Another challenge for Medicaid therapy services is the reimbursement rate for multiple disciplines. At our facility due to reimbursement, we only treat 1 therapy/day, due to not receiving full payment if all 3 therapies are provided in 1 day. This again, leads to a great burden to the families that are traveling a great distance for multiple days.

Rural health care challenges are not new; however, low reimbursement rates impact the burden to fill therapy vacancies with facilities having to increase the pay rate to attract therapist or use traveling companies. This is a huge cost to any organization. If therapist cannot be maintained this interrupts care and creates more burdens. This leads to families driving to the front range for services or not receiving therapy at all.

Holly Ross
CANOE - Building Blocks OT LLC

I am a small business owner in the state of Colorado that takes Medicaid and provides outpatient OT services. More specifically I specialize in aquatic therapy and drowning prevention for those with disabilities. Currently, I am the only provider in the state that can perform these services together because of my specialized training. I have actively looked for another provider like me and have not found one that accepts Medicaid. With 19 clients on the waitlist, I am actively hiring, training providers, and helping more patients in the community. If outpatient OT rates were to be cut, I will lose providers that work for me, and subsequently those clients will lose services and have no where to go. I could even go out of business and there would be no way for these families to get services. I also run free disability events for families & children with disabilities with resource fairs that allow families to access the community and navigate services to fit their needs. My company has been in business for 5 years and we are a vital sector for outpatient OT services. If cuts happen and my company goes out of business, those with severe disabilities, medical complexities, high behaviors, and high needs will go without services. Please do not cut Outpatient OT rates. Thank you for your time.

Heidi Kunugi
Occupational Therapy Association of Colorado

The Occupational Therapy Association of Colorado (OTAC) urges the Colorado Department of Health Care Policy and Financing (HCPF) to take immediate action to increase Medicaid provider rates for occupational therapy (OT) services. Occupational therapy is a critical component of Colorado's healthcare system, helping individuals regain independence, manage chronic conditions, and recover from injuries. OT providers play a vital role in improving patient outcomes and reducing long-term healthcare costs by preventing complications and unnecessary hospitalizations. However, Colorado's Medicaid reimbursement rates for OT services are falling behind other states with similar demographics and healthcare challenges, jeopardizing the financial stability of OT practices and threatening patient access to essential care. States like New Mexico and North Dakota, despite having lower costs of living, offer higher Medicaid payment rates, supporting workforce sustainability and provider retention. Even Texas, with its significantly lower cost of living, provides better reimbursement for key therapy codes, which helps maintain a resilient OT workforce. If Colorado does not adjust its Medicaid rates, the state will continue to face provider shortages and longer wait times, disproportionately impacting underserved and rural communities.

The OTAC's 2025 survey underscores the financial strain on Colorado's OT workforce. Many providers have faced reduced access to clinical tools, increased productivity demands, and stagnant wages due to inadequate reimbursement rates. Alarmingly, 53% of respondents report maintaining a waitlist for Medicaid patients, with 66% indicating wait times of 1-3 months. Prior authorization delays and visit limits further restrict access to care. Additionally, high student loan debt among OT professionals, combined with low Medicaid reimbursement, has created unsustainable financial pressure, making it difficult to retain qualified providers. OTAC strongly recommends a 10% increase in Medicaid reimbursement rates to align Colorado with other states and support the financial viability of OT practices. Increasing rates would expand access to OT services, particularly in rural and underserved areas, reduce wait times, and strengthen Colorado's healthcare infrastructure. We urge Colorado policymakers to act swiftly to secure the future of OT services and ensure that all Coloradans have access to the rehabilitative care they need to maintain health and independence.

Alexa Herbers
Colorado Speech Language and Hearing Association

Hi my name is Alexa Herbers. I am a speech-language pathologist and pediatric private practice owner in Denver. Additionally, I serve as the State Advocate for Reimbursement for the Colorado Speech and Hearing Association (CSHA) and am on the Committee on Medicaid for the American-Speech-Language-Hearing Association (ASHA).

Within my private practice, I am an early intervention provider. The Colorado Department of Early Childhood and state early intervention program allots a speech therapy stipend to speech therapy providers who bill Medicaid. This stipend allows speech language pathologists, who are billing Medicaid at a low reimbursement, to be paid equally with other therapeutic disciplines. No other type of provider needs to receive this stipend. A state program recognizing and compensating for the low reimbursement rates that speech therapists receive speaks for itself.

Every day SLPs in Colorado are making the difficult decision on whether or not they can afford to work with Medicaid beneficiaries. With SLPs accepting fewer Medicaid patients, delays in care can serve as not only a significant detriment to the patients but yield longer time within programs, longer stays in inpatient settings, and longer use of speech therapy intervention. Prolonged or delayed care ultimately costs payer sources more and affects patients' quality of life. With a higher reimbursement rate these needs can be met.

Thank you for hearing us today and considering making these changes.

Molly Hahn-Floyd
Occupational Therapy Association of Colorado

As president of the Occupational Therapy Association of Colorado (OTAC), I urge the Colorado Department of Health Care Policy and Financing (HCPF) to take immediate action to increase Medicaid provider rates for occupational therapy (OT) services. Occupational therapy is a critical component of Colorado's healthcare system, helping individuals regain independence, manage chronic conditions, and recover from injuries. OT providers play a vital role in improving patient outcomes and reducing long-term healthcare costs by preventing complications and unnecessary hospitalizations. However, Colorado's Medicaid reimbursement rates for OT services are falling behind other states with similar demographics and healthcare challenges, jeopardizing the financial stability of OT practices and threatening patient access to essential care. States like New Mexico and North Dakota, despite having lower costs of living, offer higher Medicaid payment rates, supporting workforce sustainability and provider retention. Even Texas, with its significantly lower cost of living, provides better reimbursement for key therapy codes, which helps maintain a resilient OT workforce. If Colorado does not adjust its Medicaid rates, the state will continue to face provider shortages and longer wait times, disproportionately impacting underserved and rural communities.

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XXXXX

I am XXX in the community that receives Outpatient Occupational Therapy. I am writing today to request and advocate that you do NOT cut rates for the services XXX receive. These services are important for XXX and without these services they would decline in function and struggle exponentially. These services offer XXX to have mobility, autonomy, and have the chance to play a role in society. Please do not cut rates for Outpatient occupational therapy . Cutting these services could cause my current provider, XXX, to go out of business, then my XXX would be left without medically necessary services that are helping XXX thrive. Thank you.

XXXXX

XXX is non-speaking autistic. The services provided by outpatient OT and SP have been pivotal in XXX progress of learning specifically working with OT in the pool learning how to swim, has been the most effective for XXX something XXX looks forward to every time and has impacted all of XXX other learning and other services. Without this guidance, I would not know how to move forward in teaching XXX not only how to swim, but doing the important aspects of occupational therapy and speech necessary. Without the services, XXX would be hindered in her growth and development.

Lauren Preston
Pediatric Therapy of Colorado

We are a company that helps children with disabilities through OT. We have witnessed firsthand the critical role that occupational therapy plays in promoting the health, development, and well-being of children, especially those from low-income and underserved backgrounds. Pediatric OT addresses a wide range of developmental, physical, and cognitive challenges, enabling children to participate more fully in their daily lives, improve their academic performance, and develop the skills they need for lifelong success. OT services have been shown to significantly improve motor skills, sensory processing, behavioral issues, and social participation.

Many children from disadvantaged backgrounds do not have access to these essential services due to barriers such as financial limitations and a lack of available providers within their communities. Research demonstrates that early access to OT can prevent the need for more intensive interventions later in life, which ultimately results in long-term savings for Medicaid and other public health systems.

OT helps children become more successful academically and socially, improving their quality of life and increasing their chances of academic achievement and social inclusion. Given the proven effectiveness of pediatric OT and its potential to improve outcomes for children with disabilities, developmental delays, and behavioral health concerns, I urge you to consider Increasing Medicaid coverage for pediatric occupational therapy. The increase rates of Medicaid would not only align with the values of equity and inclusion but also improve the lives of thousands of children who deserve a brighter future.

Thank you for your time and consideration. I hope that all children, regardless of their background or socioeconomic status, have access to the therapies they need to succeed.

Cece Landis
Pediatric Therapy of Colorado

My profession is the base foundation towards giving quality of life for others and l creating independent lives so people can live in harmony. Please keep this in mind when debating whether to cut funding which aids anyone needing support to become independent in life because the disability community is a community which anyone can become apart of at any time in their lives.

Kim Gully
Paradigm Health Solutions

Medicaid outpatient cuts would cause clients with disabilities to lose care for OT, PT, SLP, and ABA increasing problems with their disabilities and mental health which would also put strain on their families who depend on these services. My DPT could lose her practice which would also cause me to lose my job which would impact multiple families who depend on our services as well as my livelihood.

Ava Solman
Pediatric Therapy of Colorado

I am advocating for increasing the Medicaid reimbursement rates for Occupational Therapy. We are a field that focuses on increasing functioning in daily life and independence. When individuals are able to be independent and actively engage in daily tasks effectively and efficiently, their quality of life, health and wellbeing increases, and this saves a significant amount of healthcare costs.

I specialize in Occupational Therapy for individuals experiencing PTSD. The CDC calculates that childhood trauma is our single largest public health issue—more costly than cancer or heart disease—and one that is largely preventable by early prevention and intervention. Providing intervention for children who have survived trauma not only helps children heal and move through development milestones in order to become healthy, functional, productive adults but it also prevents disease later in life, again, saving on healthcare costs.

Due to the impact Occupational Therapy has on the wellbeing of all humans, the positive impact on healthcare costs, decreasing the burden on healthcare facilities, and the inflation costs of housing, goods and services, I am strongly advocating for an increase in Medicaid reimbursement for Occupational Therapy services. Occupational Therapist make a huge positive impact on people's lives and an increase in reimbursement rates will allow us to continue this important work. When therapists are able to meet their own financial, health and wellbeing needs, we are able to best support those needs for others.

Thank you for your time and careful consideration!

Chris Edmundson
Integral Physical Therapy

During the last MPRRAC meeting you requested that the APTA send along research on exercise as preventative healthcare. Please see the attached document with a sampling of some of this research in various domains of health.

Please let us know if you have any questions or require additional information.

Link to feedback

Orthomerica

Link to letter

Specialty Care Services

Dave Richard

I am a former Medicaid director in NC and now consult with organizations on health care issues. One organization I represent is Kerecis who produces a skin graft product made from fish skin. [a link to their website is below.]

Colorado just recently approved coverage of the product using code Q4158. We are appreciative of the decision to approve coverage but are concerned with the rate assigned.

We are writing to determine how to request an off-cycle review of the rate established for Kerecis Omega3 skin graft product.

Unlike other skin graft products our product comes in various sizes which allows for the physician to fit the graft to the size of the wound without the waste that occurs with other products.

Colorado has priced this at $14.35 regardless of size. This amount would not cover the cost of the product especially when considering that it comes in different sizes. Most states and Medicare price the produce per centimeter. For example, Georgia Medicaid just approved Kerecis at $100 dollars per centimeter.

We have a significant amount of additional information we can provide to you to consider an off-cycle review but wanted to first contact you on how to formally request such a review.

Intact Fish Skin for Tissue Regeneration - Kerecis.com

Jason Brabson
Heart & Soul Paratransit

I'm an NEMT provider in Larimer County. As of July 1st the rate change for Extra large Wheel Chair transportation was reduced by 95% with no warning and without any official reduction. This was done by reclassifying the billing code. This will reduce our revenue by over 80% and severely limit our ability to provide services.

My question is, was this approved by the Rate committee and is standard practice to change a billing code that significantly reduces the ability of a provider to survive and continue to provide critical services?

Is there any way to get the billing changed back to allow providers some time to prepare for such a massive reduction in revenue?

Targeted Case Management (TCM)

Ellen Jensby
Alliance

I have been talking to a couple of our member experts and, although they are out next week for the holiday, will be back in the office the following week and we believe we can pull together a couple of state examples by Tuesday the 7th at latest.

There are a few nuances that require a bit more digging than I originally thought:

- Although Colorado pays TCM as a "per member per month", that is a term typically reserved for managed care configurations in which the managed care entity gets paid for the service regardless of whether or how much they provide. Colorado's PMPM is really just a monthly billing unit, which can only be billed if a service is provided in a given month. So far, we are unaware of other states that have a monthly billing unit, which is why we need a bit more time.
- In some states, the state agency itself is responsible for intake, assessment, and sometimes other functions that our CMAs do in Colorado. This has impacts on the TCM rate, because those dollars must be spread across a wider range of activities than just what is in the definition of TCM. So, we want to be careful to exclude any states whose CM activities do not closely mirror Colorado's.
- We also think that states who have a managed care configuration can be excluded. Kansas is one of these, although the information we found online is convoluted with respect to how TCM fits in. Our expert will look into this as well.

Our member volunteers who have been researching this got me an update earlier today, but we are not as far along as we had hoped to be with the details of the states we are looking at. However, I will share with you as much as I can with a promise that we are going to continue to work on this and will offer more information in the future.

First, it's important to note that states may have more than one type of case management service for different waivers/programs/populations. This has made our research more complicated, but we have reviewed states and eliminated those that have different case management models (including Managed Care for long-term services and supports, Waiver Case Management, or Administrative Case Management) as these are structured differently from TCM. To find the below list of states, our

volunteers reviewed at least one IDD waiver in the state and determined that the state uses TCM for this population. Because people with IDD typically have higher needs and utilization related to case management, we felt this is the best population to use for comparison purposes. Those states are:

Alaska
Alabama
Maine
Missouri
Montana
Nebraska
Nevada
Oklahoma

I will note we have not made it deeply into these states' financing mechanisms, so they may not all be good comparisons, but this list should at least be a place to start.

Two states you had noted in your email, Kansas and Florida, are a bit more complicated and our research is pending for these –

- Kansas lists TCM for its waivers, but we know the state has managed care, so we are working to understand how TCM is impacted by this alternative model. Colorado does not have a managed care system, so there may be fundamental differences that make comparison impractical.
- Florida – as far as we can tell, Florida uses Waiver Case Management for its IDD waivers, not TCM. It appears to use TCM for other populations/programs, but a deeper dive is needed to determine whether it could truly be compared to Colorado due to the different populations served.

As I noted in my last email, we continue to struggle with a few concerns of which we would love your contractor and SMEs to be aware:

- We have not yet found any other states that pay TCM based on a monthly unit as Colorado does.
- When comparing to other states, it is important to look at the number of people being served as well as the population served. E.g., if TCM is only used for one waiver with 1,000 enrollees, the way it is done will likely look substantially different from Colorado, where Case Management agencies are doing TCM for tens of thousands of enrollees across multiple waivers. Population needs also vary. We know that people on the EBD waiver require

very different levels of case management than people on IDD waivers, for example.

- As mentioned in my last email, we continue to find many states that separate intake and level-of-care determinations from the case management agencies, performing these activities out of the state agency itself. This is fundamentally different from CO, where the CMA is responsible for these activities as well as TCM, and therefore they have the added complexity of managing both a state contract that is a federal subaward and a fee-for-service program, which drives additional admin costs for CMAs.
- Again, we want to emphasize the importance of clarifying for MPRRAC members that Colorado's "per member per month" is NOT the same as a PMPM under a managed care system, where the managed care entity is paid a set amount per enrolled member regardless of how much service each person receives. This model provides a stable source of revenue for the managed care entity and allows them flexibility to work within that revenue on a risk-basis. Colorado's model, however, is a monthly fee-for-service unit that can only be accessed once a contact is made with the member, so revenues are less stable and fluctuate more. We will likely be articulating this further in later comments.

Thank you for your attention to this, and we look forward to learning more about these states with you.

Kim Tenure
Developmental Pathways

Hello, my name is Kim Tenure, and I'm the Associate Director or Disability Policy at Developmental Pathways and we are a member of Alliance, so I am also speaking on behalf of them.

The LTC/LTSS system just went through a massive systems change with a number of complications that out our organization (Case Management Agencies (CMAs) across the state) in crisis mode. These changes included the launch of a new technology system that replaced a 20 year old legacy system, PHE unwind, and Case Management Redesign that aimed at simplifying the system, but also changed the number of CMAs from 44 to 15. We are still in the stabilizations phase from those changes and are struggling to hire and retain enough staff to perform essential case management functions.

Additionally, there are also a number of new systems changes planned for this year. Our staff are experiencing severe burnout and fatigue trying to keep up with constantly changing responsibilities and processes.

We are all still getting used to the new system and contract requirements, and we are of course always communicating with HCPF on our challenges and trying to find solutions.

While we are beginning to capture data on funding gaps, one area we have already identified is funding for intake work, which doesn't have a discreet billing line but is built into the rate for TCM. However, we cannot bill for TCM unless a Medicaid member actually becomes enrolled, and that only happens with about 30% of those who come to intake.

So, while the initial benchmark analysis at least in part supports our experience that funding is not adequate to support our workload and adequate compensation for case managers who have incredibly demanding jobs.

We are collaborating with all CMAs to understand the challenges they face and identify solutions.

Germaine Seufert
Consultants for Children, Inc.

Our providers who offer Targeted Case Management Services are highly skilled, licensed and can provide other services if they want to. To keep the services for clients at a high quality, I would like to advocate the rates not be reduced. Understanding the multiple arenas children with disabilities are in and the need for assisting with these families at this higher level of care needed related to case management to ensure the providers involved are providing what the child and family need to reduce the long term cost for these children is clear. If they meet their goals as a younger person, they will be set up better for long term success and less dependent on medical, educational and behavioral providers.

Please consider not reducing the Targeted Case Management rates.

As a provider with 117 clients, mostly in rural Colorado, rates being reduced would impact our ability to provide this service for our clients.

Thank you for your consideration.

Kathleen Leubner
Pediatric Therapy of Colorado

Early Intervention is such a vital service for children and families that need that in-home support. In my role as an OT, I empower parents to best support their children's development and allow them to thrive.

Vision Services

Janelle Shumaker
Hero Practice Services

Dear MPRRAC,

My name is Janelle Shumaker, and I partner with a group of children's dental and vision practices dedicated to serving underserved communities. I have extensive experience working with providers across seven states, all of whom accept Medicaid. In Colorado, I collaborate with 11 children's vision practices along the Front Range and support a CO Rural Vision program that addresses the significant lack of access to vision care in rural areas.

I am writing to formally submit comments on the rate review process for the three-year review of eyeglasses and vision services for Colorado Medicaid. Recently, I attended the online MPRRAC Rate Review Meeting and reviewed Appendix D, Benchmark States Rationale, as well as the Budget Proposal Summary and HCPF's recommendations on using a percentage of Medicare as a baseline for Medicaid fees.

In Appendix D, the benchmark states for vision services include Arizona, California, Louisiana, Nevada, and Oklahoma. I would like to formally request the removal of California from this comparison. California has some of the lowest vision fees in the country, which often do not justify the chair time for providers to see Medicaid patients.

Additionally, California has an extremely low utilization rate for children on Medicaid receiving vision services. In 2022, only 17.49% of children on Medicaid received a comprehensive eye exam.

Typically, low utilization rates are linked to poor reimbursement. I urge MPRRAC to consider using New Mexico as a benchmark state instead of California. As a neighboring state to Colorado, New Mexico's demographics, including the cost-of-living index, are much more comparable than those of California. New Mexico's current Medicaid fees reflect the state's investment in vision services and highlight the importance of eye care for children, especially as it impacts their learning in the classroom. Poor vision can significantly hinder a child's ability to read, engage in classroom activities, and overall academic performance.

In the Budget Agenda Summary, section R-09 Provider Rate Adjustments, HCPF proposes using Medicare as a benchmark for provider rates.Their proposal includes adjusting provider rates that exceed 95% of Medicare. This is a valid benchmark across various healthcare categories. Colorado's vision rates do not exceed this benchmark and adjusting them based on states with low utilization rates could negatively impact Medicaid members. I understand that 91% of the codes being reviewed will use the Medicare benchmark, while 9% will use the state comparison. However, I am concerned about the benchmark range, which spans from 40% to 143%. California significantly skews this range when considering the blended rates among the six comparison states. This could lead to an unfair comparison and potentially influence reviewers' opinions based on an inappropriate benchmark.

Please consider using New Mexico in place of California for the comparison state. If the MPRRAC has any questions regarding my request, I am happy to participate in further discussions.

Sincerely,
Janelle Shumaker
VP, Payor Relations
Hero Practice Services

https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2022-23-Preventive-Services-Report.pdf

https://www.viennaeyecarecenter.com/the-impact-of-poor-vision-on-childrens-learning-abilities/

https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202025-2026%20Budget%20Agenda%20Summary-B.pdf

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Emily McCourt
Children's Hospital Colorado

Thanks for the opportunity to provide input for the MPRACC. I thought a lot about this and have solicited input from many of my colleagues. In the vision / eyeglasses category, I would propose the following 6 changes:

1. Aspheric glasses – This should be restricted to patients with refraction above or below 8 diopters (+ or -8 or higher) and if indicated is medically necessary by the prescribing ophthalmologist or optometrist.
2. Glasses for patients over 21 years old – Glasses benefits should be extended to patients who are adults who also carry a diagnosis of intellectual disability. For many patients this could be the difference between being able to work. Could restrict to those with refractive errors of more than +/- 2.00 diopters if needed.
3. Contact lenses – This should be extended from aphakia and keratoconus diagnosis to patients with ocular surface disease, corneal irregularities, neurotrophic cornea, corneal scarring. Contacts for these indications are not cosmetic; instead these should be considered medical equipment for vision since in these cases glasses cannot correct their refractive error.
4. Corneal Collagen Crosslinking 0402T – The ophthalmology community is thrilled that this vision saving procedure is covered by Colorado Medicaid but with the low reimbursement, many ophthalmologists are not providing this service to patients with Medicaid. For example, Tricare pays $9,259 per eye and Colorado Medicaid covers this at $260.22. Commercial insurances pay between $4k and 8k per eye. Poor reimbursement with low professional fees decreases access to care for patients who have Medicaid in Colorado. The professional fee for this should be increased.

   Crosslinking has been proven to be cost saving long term in the treatment of keratoconus since it prevents the need for corneal transplantation, a surgery that is expensive, high risk, and usually results in multiple subsequent eye procedures.

5. Vision Therapy – This should not be a covered benefit and should be restricted. "Orthoptic and pleoptic vision therapy" is a treatment that is prescribed by optometrists for learning disorders and strabismus, but it has virtually no evidence supporting its efficacy. The American Academy of Pediatrics, American Academy of Ophthalmology, and American Association for Pediatric Ophthalmology and Strabismus all have policy statements discouraging the use of optometric vision therapy for most patients.

The only indication for which there is reliable evidence is a form of strabismus called convergence insufficiency. For all other indications vision therapy is not medically necessary or standard of care. 7 CPT codes that are typically used for vision therapy: 92065, 92066, 97110, 97112, 97530, 97532, 97533 - most of those codes are not eye-specific, but their use by an optometrist or ophthalmologist would almost exclusively be for vision therapy.

Private insurers and most state Medicaid plans do not routinely cover vision therapy for any indication other than convergence insufficiency since it is not an evidence-based treatment (see links below)

6. Refraction – 92015. Refraction is separate diagnostic test that is not included in the AMA definition of a comprehensive eye exam. Many state Medicaid programs pay ophthalmologists and optometrists when we perform a medically necessary refraction as part of EPSDT's legal requirements. (Below are links to other states' Medicaid policies for 92015 for comparison.)

Additionally, a refraction in a typical child is very different than a baby, non-verbal child, teenager with autism, etc. I propose if 92015 cannot be covered for every child, that it should be covered for patients with secondary diagnosis (Down Syndrome, intellectual disability, autism, medical eye disease, etc) which preclude a typical refraction – adults or children. This would help incentivize eye doctors to take care of our most vulnerable patients.

LINKS for vision therapy:
Joint American Academy of Pediatrics and American Academy of Ophthalmology statement:
https://publications.aap.org/pediatrics/article/124/2/837/72351/Learning-Disabilities-Dyslexia-and-Vision?autologincheck=redirected

Vision therapy not covered by United, Anthem, Aetna:
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/visual-information-processing-evaluation-orthoptic-vision-therapy.pdf

https://le.anthem.com/pdf?x=OH_SH_PPO

https://www.aapc.com/codes/webroot/upload/general_pages_docs/document/mm_0221_coveragepositioncriteria_vision_therapy_orthoptics.pdf?srsltid=AfmBOorregAh2za7I-qOBJks8yPlfTWKUfuVQl1VNjPvVYHrpeNrp9lQ

https://www.aetna.com/cpb/medical/data/400_499/0489.html

Links for other state Medicaid covering refraction
Texas: "Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014." "Procedure code 92015 must be used to bill Texas Medicaid

for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only."
https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2019/2019-10-2_Vision_and_Hearing_Srvs.pdf

Indiana: "Determination of refractive state (92015) performed by an optometrist or ophthalmologist is covered : A. Once every (12) months, for members under 21years of age B. Once every (24) months, for members 21 years of age and older"
https://www.caresource.com/documents/medicaid-in-policy-reimburse-py-0814-20190920#:~:text=Refractive%20Services%2D%20The%20act%20or,the%20prescription%20of%20corrective%20lenses.&text=intermediate%2C%20established%20patient-,D.,does%20not%20confirm%20medical%20necessity.&text=III.,included%20in%20an%20eye%20exam.&text=all%2Dinclusive%20and%20is%20subject%20to%20updates.&text=Date%20Effective%2011/1/2019,active%20and%20has%20been%20archived.

Kansas: "Refraction (92015) is not included in a basic eye exam. Refractions may be provided on the same date of service as the basic eye exam and billed as a separate procedure."
https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/775-Vision-manual%20updatesV2.pdf

Missouri: "An eye refraction (procedure code 92015) may be billed with the appropriate exam code when the exam includes the refraction. Eye refractions are not covered by Medicare but are covered by the MO HealthNet." (MO HealthNet is their state Medicaid program.) Code 92015 is reimbursed $5 by Missouri Medicaid, in addition to the E/M or eye code when they're performed on the same day.
https://manuals.momed.com/collections/collection_archive/collection_opt/Print_05042017.pdf

Kentucky: 92015 is covered once per year.
https://www.chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2023VisionFeeSchedule.pdf

Nevada: Refraction is covered once per year. If refraction is medically necessary more frequently than once per year, prior authorization is required.
https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3327_20240404.pdf
and
https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT60.pdf

New Hampshire: New Hampshire Medicaid explicitly pays $21.84 extra when a routine eye exam includes a refraction, as shown by their definition and reimbursement of codes S0620 and S0621.
https://internal-prm.olmdev.com/dam/jcr:15dfa938-5065-405b-8125-8e365bc4ca6e/VSP%20New%20Hampshire%20Medicaid_01012023.pdf

Thank you again for the opportunity to provide input on how we can better help the children of Colorado. As both an ophthalmologist and a tax payer, I appreciate it! Feel free to reach out with questions and I'm happy to elaborate on any of these topics.

Colorado Optometric Association

Feedback on 2025 Eyeglasses and Vision Rate Review

The last significant increase in reimbursement for eye related services took place in 2015. Prior to that increase, Medicaid paid less than 30% of Medicare which did not allow for widespread provider participation. With the current fee schedule, almost 80% of Colorado optometrists are enrolled as providers for Health First Colorado. Eyeglass and Vision Services were last reviewed by the MPRRAC (Medicaid Provider Rate Review Advisory Committee) in 2022. At that time, those services were estimated to be at 57.4% of benchmark (even after the rate increase of 2015). The recommendation from that review was to increase any rate that fell below 80% of benchmark to 80% and to decrease any rate above 100% of benchmark to 100% with the following conclusion, "Given that vision rates are below 80% of the benchmark, this indicates that rates may be insufficient...and may not support appropriate reimbursement for high-value services."

While adjustments were made related to benchmark, we have found that the benchmark doesn't always reflect the actual cost of goods. For example, V2744 (photochromic tint) reimburses $15.29 per lens while labs charge $35 and V2750 (antireflective coating) reimburses $17.79 per lens while labs charge $25 for the lowest end version of each of these products. That would result in a significant loss to provide those options to Medicaid members. As of January 1, 2025, optometrists, along with all other physician providers, will be subjected to a 2.8% pay cut from CMS for Medicare services. The cost of operating a clinic and providing services and materials has increased significantly with inflation over the past few years. We would ask for no further cuts to eyeglass and vision services at this time as there are

very few services or materials that are being paid above benchmark and we want to maintain a strong network of Medicaid providers across the state.

Kris Ekeren
Colorado Optometric Association

Feedback on 2025 Eyeglasses and Vision Rate Review

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While adjustments were made related to benchmark, we have found that the benchmark doesn't always reflect the actual cost of goods. For example, V2744 (photochromic tint) reimburses $15.29 per lens while labs charge $35 and V2750 (antireflective coating) reimburses $17.79 per lens while labs charge $25 for the lowest end version of each of these products. That would result in a significant loss to provide those options to Medicaid members.

As of January 1, 2025, optometrists, along with all other physician providers, will be subjected to a 2.8% pay cut from CMS for Medicare services. The cost of operating a clinic and providing services and materials has increased significantly with inflation over the past few years. We would ask for no further cuts to eyeglass and vision services at this time as there are very few services or materials that are being paid above benchmark and we want to maintain a strong network of Medicaid providers across the state.

Matthew Scott
Colorado Optometric Association

The Colorado Optometric Association (COA) appreciates the work, communication and efforts of the Medicaid Provider Rate Review Advisory Committee. In light of the difficult budgetary times facing Colorado, we support and applaud the recommendation of the committee to increase reimbursement to 80% of benchmark for those codes that are currently reimbursed less than 80%. This will help ensure the continued participation of our strong network of providers across the state, especially those in underserved communities.

Physician Services - Allergy and Immunology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Cardiology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Dermatology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - ED and Hospital Evaluation and Management (E&M)

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Ear, Nose, and Throat (ENT)

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Family Planning

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Gastroenterology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Gynecology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Health Education

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Medication Injections and Infusions

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Neuro/Psychological Testing Services

Lila Kimel
Kimel Psychological Services

I am really concerned about our testing code rates being so low. The state is not keeping up with the cost of living increases, yet my testing clinicians expect raises and bonuses every year to retain then. For testing, we bring in by the hour less than what a master's level psychotherapist makes for one hour of psychotherapy (in my practice this is $156 per hour). Our testing rates are much lower than those of many other states. I am concerned that I will not be able to keep my small group psychology practice affloat, testing children and young adults for autism and other developmental disabilities if these rates do not go up.

Dr. Lisa Michelle Griffiths
Center for Valued Living, PLLC

Dear Members of the Joint Budget Committee and MPRRAC,

Thank you for your continued attention to the autism (ASD) crisis in Colorado and for supporting the need for psychological testing for ASD. Unfortunately, many psychologists, myself included, face significant barriers to attending public meetings where important issues like this are discussed, as they are often managing full clinical caseloads, running practices, or committed to pre- scheduled obligations. These meetings are typically scheduled as full-day or multi-day sessions without designated time slots for specific agenda items, making it difficult for providers to set aside entire days for when the specific issues we would be interested in are addressed. With this in mind, please accept this letter in lieu of me providing testimony at the July 18 and July 25 MPRRAC meetings, as I was unable to attend.

I am writing as a licensed psychologist and group practice owner who has long provided psychological testing services to Medicaid recipients across the state, particularly those seeking evaluation for Autism Spectrum Disorder (ASD). I am the only remaining provider at my practice able to offer these assessments, only offering 1-2 a month maximum; my capacity as a group practice owner is severely limited due to current reimbursement rates that make it financially unsustainable to retain qualified staff and my principal duties are to manage the practice. However, my passion and commitment to the ASD community is steadfast, and I hope that the

MPRRAC and JBC committees make updates to psychological testing reimbursement rates consistent with this proposal, which will enable me to hire more psychologists to do this important work.

Notably, our practice also offers psychological evaluations in bariatric assessments, which is a required component for clearance for surgery for Medicaid Members. We are one of the few practices in the state that specializes in this niche area, which requires extensive training and expertise. We collaborate with the bariatric department at UHC Health, as they have a many-months-long waitlist to complete psychological evaluations. While we supplement their ability to get evaluations done more quickly, our waitlist is lengthy as well, as again, we have trouble hiring psychologists who can live sustainably off Medicaid wages once our overhead is factored in. At present, we have one part time psychologist on staff who does these, and we get six to eight calls a week on average, but she can complete up to four per week maximum. I would like to hire more psychologists and train them to do this work as well.

Throughout the years of communication with HCPF, MPRRAC and the JBC, one core issue persists— the low reimbursement rates for psychological and neuropsychological testing services required for ASD diagnosis and care planning (as well as bariatric evaluations for our practice). The current (and historical) rates do not reflect the expertise, time, or resources required to deliver ethical, thorough, and clinically sound evaluations.

Below is a sample breakdown of the most commonly billed testing codes by testing psychologists and their current rates (as of July 1, 2025):

CPT Code	Description	Allowed Units	Rate
90791	Initial diagnostic intake (2 hrs, 1 unit allowed)	1	$162.22 / $167.56 (GT)
96136	First 30 min of test administration	1	$69.16
96137*	Additional 30-min units (typically 7+)	Multiple	$50.64

96132	First hour of interpretation/report writing (neuropsych)	1	$136.66
96133*	Additional neuropsych hours (typically 8–10+)	Multiple	$104.22
96130	First hour of interpretation/report writing (psych)	1	$134.53
96131*	Additional psych testing hours	Multiple	$106.55

As shown, most of the hours worked—especially on add-on codes (noted by a *) —are reimbursed at lower rates, despite being
direct extensions of primary codes requiring the same level of expertise.
Furthermore:

- A full ASD battery requires 12–20+ hours of professional time.
- Each ASD evaluation incurs $250–$300 in non-reimbursable testing material costs (which are rising).
- Providers cannot bill Medicaid clients for no-shows, often resulting in lost revenue despite reserved clinical time.
- Overhead expenses and the need to pay licensed psychologists a livable wage further compound the financial burden.
- Also notable -- psychologists do not typically use CPT codes 96127, 96110, or 96113, despite these codes appearing among the top 10 most frequently utilized psychological testing codes in Colorado. These are codes typically used by other medical personnel.

Due to these unsustainable conditions, many providers have already ceased offering ASD evaluations to Medicaid recipients, including the entire assessment department at Wellpower, which just closed in June 2025 and will contribute to even fewer options for people to seek necessary care. Without immediate action, this access gap will continue to widen. We urge you to:

- Equalize reimbursement rates for primary and secondary/add-on codes by raising the rates of 96137 to match 96136, 96133 to match 96132, and 96131 to match 96130.

- Recognize that psychological testing for ASD and bariatric surgery is an essential, non-discretionary medical service that guides diagnosis, treatment planning, and service eligibility.
- Understand that improving rate structures now will reduce long-term state costs through earlier intervention, targeted care, and reduced strain on other public systems.

We appreciate the acknowledgment in the July 25 meeting that reducing rates is not the solution, and we support the proposal to align add-on and primary code reimbursement. We ask the JBC and MPRRAC to adopt this recommendation as part of the upcoming budget planning cycle.

Thank you for your time and commitment to ensuring equitable ASD and bariatric care in Colorado. I would welcome the opportunity to discuss this matter further with any committee members.

David Hatfield, Oliver Behavioral Consultants
Chrsitina Aegerter, ACTivation
Alexandra Ament, Kind-Minded Psych
William Boenig, Ascend Behavior Partners
Heather Carroll, Carroll Therapy Connections
Nancy Cason, Insights Colorado Assessment and Therapy
Nomita Chabildas, Licensed Clinical Therapist
Kata Colon, Elevated Insights
Bethany Coop, ClearPath Behavior Solutions
Ryan Cole, Brain and Body Integration
Claire Dumke, Insights Colorado Assessment and Therapy
Jennifer Geiger, Community Neuropsychology
Lisa Griffiths, Center for Valued Living, PLLC
Jackie Hansberger, Ascend Behavior Partners
Shannon Huntsberry, Shannon Huntsberry, LPC, LLC
Lauren Kerstein, Lauren H. Kerstein LCSW, P.C.
Lila Kopelioff, Kimel Psychological Services
Alex Littleton, Vivid Psychology Group
Nicole Da Lima Leitao, BehaviorSpan
Meghan Lee, Horizon Neuropsychological Services
Meade McCue, Developmental FX
Jonathan Mueller, Ascend Behavior Partners
Henrietta Pazos, New Horizons/ Nuevos Horizontes
Chelsea Quick, Action Behavior Centers

Jennifer Paz Ryan, Elevated Insights Assessment, LLC
Lisa Shanken, Tri-Wellness
Jeremy Sharp, Colorado Center for Assessment
James Tomash, BehaviorSpan
Abigail Wischkaemper, Soar Autism Center
Brian Wolff, Wolff Child Psychology
Deanna Zarei, Autism Insights, PLLC

Dear Members of the Medicaid Provider Rate Review Advisory Committee (MPRRAC),

We, the undersigned group of healthcare providers, psychologists, and organizations across Colorado, are writing to express our shared concern about the inadequacy of Medicaid reimbursement rates for psychological and neurodevelopmental evaluations used to diagnose Autism Spectrum Disorder (ASD), Intellectual and Developmental Disabilities (IDD), and Global Developmental Delay (GDD). These rates, which are scheduled for review by MPRRAC in 2025, are critically misaligned with both the complexity of the services provided and the qualifications required to deliver them. The result is a crisis in access to essential diagnostic services for children and families throughout the state; children are sitting on waiting lists for 12 to 24 months for ASD and developmental disability diagnoses during a time of peak neuroplasticity and a shrinking provider pool that is increasingly challenged to serve them. This is especially true for Colorado's growing Hispanic/Latinx communities who require assessment services in Spanish.

The reimbursement methodology currently relies on Medicare, which does not reflect realistic market costs for these services nor ensures adequate access to care. Most evaluations use the following billing codes:

- 96130 – Psychological testing evaluation (first hour)
- 96131 – Each additional hour of psychological evaluation services
- 96132 – Neuropsychological testing evaluation services (first hour)
- 96133 – Each additional hour of neuropsychological evaluation services
- 96136 – Psychological or neuropsychological test administration and scoring (first 30 minutes)
- 96137 – Each additional 30 minutes of test administration and scoring

These codes are central to conducting comprehensive evaluations that meet clinical standards and payer requirements. However, the current Medicaid reimbursement for these codes is insufficient to cover the actual cost of services. A minimum increase of 30% is necessary across these codes to make them financially sustainable and to support continued provider participation.

Any reduction in reimbursement for these codes would exacerbate existing access issues, leading to longer waitlists, fewer participating providers, and growing inequities in care. This is especially problematic because:

- The current average reimbursement (~$105/hour) is significantly below market rates and professional compensation for similarly complex services.
- These evaluations must be performed by doctoral-level clinicians with extensive training, yet they are reimbursed at a rate less per hour than master's-level clinicians for supervision and $20 less per hour than master's-level mental health therapists for psychotherapy.
- Evaluations are reimbursed 25–40% less than psychotherapy rates, even though they require more clinical expertise and training, integration of testing data, and responsibility.
- Currently, there is no reimbursement for translating evaluation reports from providers to families which means bilingual providers who evaluate do not receive compensation for the necessary time spent serving clients.
- Testing material prices have increased significantly in 2025, making protocols expensive and the cost of rendering services even higher. Now, most test makers are requiring payment for each "use" of their online materials and each time a test is scored.

Due to these disparities, many qualified psychologists opt out of providing evaluations for Medicaid, and we are seeing the direct impact:

- Waitlists of 12–24 months for ASD evaluations, with higher waitlists for Spanish or bilingual (English/Spanish) speakers.
- A shrinking provider pool, with only around 20 provider groups statewide conducting evaluations for Medicaid-covered patients.
- Families having fewer options for evaluations, with private pay costing between $200- $250 per hour, or $2,500 to $5,000 for a total evaluation, which is simply unaffordable for most families.
- Providers unable to hire psychologists and neuropsychologists in testing practices due to low compensation rates. Most potential employees would rather take jobs at practices that are able to pay them more and don't accept Medicaid clients.

This gap in access has broad implications. Most commercial plans will not authorize habilitative treatments (like ABA) without a formal ASD diagnosis. Since many of those plans align their reimbursement structures to Medicaid fee schedules, low Medicaid rates affect the entire system, further restricting access for families regardless of funding source.

Additionally, we want to highlight that two billing codes—96110 (developmental screening) and 96127 (emotional/behavioral screening)—have historically not been open to psychologists and other qualified providers under Medicaid. These codes are

not included in the April 2025 Behavioral Health Billing Manual. We believe enabling access to these codes would provide a valuable mechanism for early screening and identification and should be considered as part of this year's review.

We respectfully urge the Committee to take the following actions:

1. Increase reimbursement rates by at least 30% for codes 96130, 96131, 96132, 96133, 96136, and 96137 to come closer to alignment with market benchmarks.
2. Avoid any reduction in rates, which would further limit access and deepen disparities.
3. Open billing codes 96110 and 96127 to qualified providers and include them in future billing manuals to support screening and early intervention.
4. Ensure all rates reflect the skill, time, and qualifications required to deliver these complex and essential evaluations.

The reimbursement crisis surrounding these codes is not a technical issue—it is a frontline access issue that affects children's ability to receive timely diagnoses and life-changing treatment. Without reform, we will continue to see reduced provider participation, increased delays in care, and worsening outcomes for the most vulnerable children in our state.

We thank you for your consideration of these concerns and are prepared to support the Committee in developing sustainable, data-informed solutions that promote access, equity, and clinical excellence.

Elizabeth Freudenthal
Children's Hospital Colorado

Neurological/psychological testing: HCPF released guidance in 2020 that providers use 96127 for autism-only screenings using only a single tool, M-CHAT--Modified Checklist for Autism in Toddlers. Providers need to use 96110 for secondary same-day screenings (other tools, autism only). Then 96110EP for all other screenings outside of autism-specific tools/screenings.
https://hcpf.colorado.gov/sites/hcpf/files/Bulletin_0620_B2000449.pdf

The peer states used for benchmarking are not using the codes in this way, which is unique to Colorado. We request that HCPF revise its analysis in consultation with pediatric primary care and developmental providers to ensure that it's accurate. Thank you.

Jennifer Rudnik
Health Solutions

Hello to all the Stakeholders on the call and thank you for the opportunity to speak today. My name is Jennifer Rudnik, and I'm here to urge the state to consider creating an increased reimbursement rate for PHQ-9 follow-up visits within integrated healthcare systems. These follow-ups are a critical component of identifying and managing depression—a condition that affects over 20% of adults in Colorado during their lifetime according to Colorado Health Access Survey, 2021. In an integrated care model, behavioral health is not siloed. It is woven into the very fabric of primary care, and throughout the new BHA Rules which allows us to reach patients earlier, more effectively, and more equitably. But despite the proven value of early mental health intervention, the current reimbursement rates for PHQ follow-up visits are disproportionately low or $0. This discourages providers from investing in the time and resources needed for regular, structured follow-ups—especially when these visits often involve complex care coordination, motivational interviewing, and safety planning.We know that PHQ follow-ups are not simply checking a box. They are an evidence-based strategy tied to better outcomes, lower hospitalization rates, and long-term cost savings for the healthcare system. Without fair reimbursement, providers face a financial disincentive to continue this crucial work, particularly in underserved and rural areas where behavioral health access is already fragile.By increasing reimbursement rates, Colorado can reaffirm its commitment to whole-person care, reduce the burden of untreated mental illness, and support the sustainability of integrated care teams who are on the frontlines of the mental health crisis.Thank you for considering this request—not just as a financial adjustment, but as an investment in health equity, patient outcomes, and the future of healthcare in Colorado.

Dr. Cassie Littler
American Academy of Pediatrics, Colorado Chapter

AAP-CO Recommendation: Protect kids by protecting benchmark ratio for all codes. Federal law mandates coverage of EPSDT services for children. Further, these 5 codes are critical in supporting a child's access to preventive developmental and behavioral health services.
Developmental & Behavioral Health Screens

- 96110 – Developmental screen with scoring (EPSDT)
- 96110-EP – Developmental screen with scoring (EPSDT)

- 6127 – Behavioral/emotional screen (autism spectrum disorder screening; EPSDT)
- G8431 – Positive depression screen, follow-up documented
- G8510 – Negative depression screen, no follow-up required

Mike Hart
Alliance Neurodiagnostics, LLC

We are in support of the 80% of Medicare recommendation as the current rates are below the cost to provide the services to members. Ambulatory EEG is critical for patients that cannot easily access hospital-based EMUs.

Physician Services - Neurology

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Primary Care Evaluation and Management

Neal Walia
Colorado Academy of Family Physicians

Please find attached a comment letter from the Colorado Academy of Family Physicians (CAFP) regarding the FY25-26 Medicaid Provider Rate Review process. Our comments focus specifically on primary care Evaluation and Management (E/M) codes under consideration by the Medicaid Provider Rate Review Advisory Committee (MPRRAC).

We appreciate the opportunity to contribute feedback and thank you for your continued work to ensure Colorado's Medicaid payment systems are equitable and supportive of primary care.

Dear Dr. Adamson and members of the Committee,

On behalf of the Colorado Academy of Family Physicians (CAFP), which represents more than 2,500 family physicians, residents, and medical students statewide, thank you for the opportunity to comment on this year's Medicaid Provider Rate Review process.

At this time of significant financial constraint, we ask that the Committee adopt a clear, consistent standard across all primary care codes: no code currently reimbursed at less than 100% of benchmark should be cut. This standard is a key advocacy priority for our membership and aligns with the intent of HB19-1233, which directed the state to strengthen investment in advanced primary care across all populations and settings.

This year's review includes numerous codes that are central to the delivery of primary care services across clinical, home-based, and long-term care settings. These include:

- Preventive visits (99381–99396): Initial and periodic preventive exams for patients across the lifespan.
- Home visits (99341–99345 for new patients, 99347–99350 for established patients): E/M services delivered in the patient's residence.
- Nursing facility (NF) visits and discharge management (99304–99310, 99315–99316): E/M services for initial, subsequent, and discharge care in facility settings.
- Preventive counseling and behavioral interventions (99401–99404 for counseling, 99406–99407 for tobacco cessation).

- Prolonged services and advance care planning (99415–99417 for prolonged clinical services, 99497 for advance care planning).

Many of these codes fall below the 100% benchmark, with some—such as 99305, 99306, 99308–99310, 99315–99316, 99401, and 99415—reimbursed at levels closer to 84% or lower. These services are not ancillary; they are core components of how family physicians deliver continuous, relationship-based care to patients across the lifespan, particularly in rural and underserved communities.

We also note that a number of these codes were reviewed and validated through the state's APM 2 stakeholder process, and reductions would directly contradict the consensus and technical rigor of that multi-year effort. Reversing those recommendations could risk undermining provider confidence in the state's process and jeopardizing progress toward Colorado's long-term primary care investment goals.

We support thoughtful stewardship of Medicaid resources—but cuts to these primary care services would generate minimal budgetary relief while causing significant disruption to care delivery, workforce stability, and access for patients. We encourage MPRRAC to work with the Department and the Joint Budget Committee to protect and strengthen the primary care infrastructure our Medicaid program depends on.

Thank you for your consideration and for your continued leadership in ensuring Medicaid payment systems are fair, evidence-based, and community-informed. We are grateful for your service.

Dr. Britt Severson

I own and operate an independent primary care clinic in Denver, which is becoming rare to find due to financial constraints of running a private practice in primary care. More and more primary care providers have stopped taking Medicaid or stopped taking insurance altogether and moved to a direct primary care model just to keep their doors open. The reimbursement rates have been too low for Medicaid for primary care. We are the providers who spend thousands of non-reimbursable hours doing refill requests, prior authorizations, medical equipment orders, FMLA forms and processing referrals because we manage all of the patient's medications and healthcare while the specialists just sees them and makes recommendations and get reimbursed at a higher rate. With only the primary care income I cannot pay my staff and I have a hard time making a competitive salary offer for a physician compared to

bigger groups like Kaiser. We have had to supplement our primary care income with procedures otherwise we could not stay open.

I love caring for patients and I especially love caring for my medicaid population but without improvements in reimbursement rates we may have to consider stopping taking Medicaid in the future. Please consider showing primary care providers their value through increasing their reimbursement rates for E/M codes for Medicaid. We are the providers who help keep patients out of the ER, hospitals, specialists and urgent cares.

Colorado Academy of Family Physicians
Colorado Chapter of the American Academy of Pediatrics
Pediatric Care Network
Children's Hospital Colorado

I'm writing on behalf of the Colorado Chapter of the American Academy of Pediatrics; The Colorado Academy of Family Physicians, the Pediatric Care Network, and Children's Hospital Colorado.

This group of provider organizations wants to thank the MPRRAC for their careful, thoughtful investments in primary care through the rate review process this year. We'd also like to support the MPRRAC's July request to add coverage of G2211 for reasons outlined in the attached letter.

Please let me or this whole group know if there are ways that we can collaborate with the committee, provide additional information, or support this request in any way that could help.

Dear Dr. Adamson and members of the Medicaid Provider Rate Review Advisory Committee,

We are a coalition of pediatric and family medicine primary care practitioners from across Colorado. We are writing to thank you for your approval of a wide variety of recommendations that, if approved by the Colorado Legislature, would infuse much-needed funding into the medical homes that serve around half a million young people enrolled in Colorado Medicaid.

In addition, we want to thank you for asking that the Department of Health Care Policy and Financing address your recommendation to add coverage of CPT code

G2211. We were disappointed with HCPF's response to your request, however. We disagree with their rationale, as explained below, and ask that you move forward with your recommendation.

HCPF's rationale for continuing exclusion of this code, as presented at your August 22 meeting, was that Regional Accountable Entities (RAEs) are paid for this service. HCPF reasons that RAEs are responsible for complex care coordination, and G2211 captures that service.

HCPF's rationale represents an incorrect understanding of G2211.

Our practices use this code as it is defined by national coding standards: a reflection of the time, resources and effort that physicians invest in building long-term relationships with patients whose complex conditions are best treated in a medical home model.

The Centers for Medicare and Medicaid Services (CMS) added G2211 to the 2024 Physician Fee Schedule in recognition of its importance to primary care. Over time, our relationships with our patients are the reason they trust and rely on a medical home, which remains the best way to provide whole-person, whole-family care, especially for people with complex needs.

G2211 is not defined as care coordination or care management, which is the RAEs' responsibility even as most of our practices provide those services as well. In addition, one-time or short-term care is excluded, even if that care involves some level of complexity. G2211 is reserved to capture only the ways we work to support our patients' long-term needs by getting to know what they need and the best ways to care for them throughout their lives.

Many of our practices bill this code to every payer regardless of coverage, because relationship-building with each patient is central to our care models.

We ask that you include this recommendation in your final report. We are available to provide any additional information that may help your committee and HCPF determine the impact of adding this code to coverage.

Thanks again for your service to Colorado, and for your support of primary care throughout this MPRRAC Cycle.

Sincerely,

Colorado Chapter, American Academy of Pediatrics
Colorado Academy of Family Physicians
Pediatric Care Network
Children's Hospital Colorado

Physician Services - Radiology

Dr. Sarah Milla, Pediatric Radiologist/ Neuroradiologist

Thank you for your work on behalf of healthcare! Pediatric Radiology sees children from all walks of life-- and we image them with care and compassion no matter what their background or circumstances are. I am hoping that decisions can help support the most vulnerable population that cannot advocate for themselves!
There is a severe nation-wide shortage of radiologists and maintaining current reimbursement rates is critical to our specialty, particularly for hospitals like Denver Health and Children's Hospital where Medicaid makes up a large portion of patients. Reducing radiological codes above 100% of Medicare would be very challenging to us to maintain the patient access and services we provide at present. We would also like to make sure that all codes are minimally above 80% of Medicare.

As radiologists, we do not choose our patient portfolio or makeup. We simply interpret imaging for any patient that needs it or comes into our Emergency Room and we are happy to do so, especially at Denver Health where that is our core mission. However, we have to be reimbursed for that cost and if rates are not keeping up with those in other states, radiologists will simply leave Colorado. That is the major concern I have, and I am hopeful that this committee will not recommend any additional cuts to radiological codes. I am also fully aware of the budget situation in the state, but I would argue that radiology is a core, critical service that affects multiple other specialties. No other specialty can do their work without diagnostic imaging, so I ask the committee to consider that in their decision making.

Physician Services - Respiratory

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Sleep Study

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Vaccines Immunizations

No public feedback was received between October 1, 2024 through October 1, 2025.

Physician Services - Vascular

No public feedback was received between October 1, 2024 through October 1, 2025.

Multiple Services

Ellen Jensby
Alliance
Services: Targeted Case Management, Early Intervention Targeted Case Management, PT/OT/SLP codes used by Early Intervention providers, and Physician Services - Neuro/Psychological Testing Services

Dear MPRRAC members,

Alliance is pleased to offer the following comments for your consideration as you review rates for **Targeted Case Management, Early Intervention Targeted Case Management, PT/OT/SLP codes used by Early Intervention providers, and Physician Services-Neuro/Psychological Testing Services**. Alliance is a statewide, non-profit association of Case Management Agencies, Community Centered Boards, Early Intervention Brokers, and Provider Agencies serving primarily Coloradans with intellectual and developmental disabilities (IDD). These comments reflect the experience of our Case Management Agency, Early Intervention Broker, and behavioral services provider members.

Early Intervention Targeted Case Management and PT, OT, and ST codes

Colorado's Early Intervention program offers services to infants and toddlers aged zero to three who have developmental disabilities and delays or are at risk of having developmental delays. These services include, but are not limited to, Physical Therapy, Occupational Therapy, Speech Language Therapy, and Developmental Intervention, which are designed to support healthy child development during the period of life when the brain is highly neuroplastic. Additionally, families receive service coordination (case management) performed by private organizations called Early Intervention Brokers, which contract with the Colorado Department of Early Childhood to perform many aspects of the program's administration and service delivery. EI services are funded by several different sources, with Medicaid covering the cost of certain services for Medicaid-eligible children. For these children, who make up 40% of children served by Early Intervention, service coordination is funded through Early Intervention Targeted Case Management.

Early Intervention has impressive results. Well established evidence from large national studies has demonstrated that up to half of all children who receive EI services do not go on to need Special Education when entering Kindergarten, and economists estimate a 13% return on investment per child per annum for high-quality 0-5 programs, with the highest return being for programs targeted towards the earliest years, such as Early Intervention. (Dr. James Heckman, "Heckman Equation" García, Jorge Luis, James J. Heckman, Duncan Ermini Leaf, and María

José Prados. "The Life-cycle Benefits of an Influential Early Childhood Program." (2016))

Because children with Medicaid come from low-income households and may not have access to other resources, timely access to Early Intervention services is especially important for them.

HCPF's benchmark analysis found that Colorado's EI TCM rate is low compared to other states. This finding is consistent with the experience of EI Brokers, who consistently report difficulty recruiting and retaining Support Coordinators to perform this work. Although funding streams for EI Support Coordination are blended, 40% of children are enrolled in Medicaid and receive EI TCM. Therefore, adequate Medicaid rates are a large component of this challenge. Because of Early Intervention's cost-saving nature and the lack of a comparable service in Medicare or private insurance, we believe the MPRRAC should recommend that EI TCM be increased to 100% of the benchmark established by HCPF's analysis. Such a recommendation would be consistent with the MPRRAC's past recommendations.

While the PT, OT, and Speech codes have analogs in Medicare, several are currently below benchmark. Because these EI services are so impactful and cost-saving long-term and are particularly important for Medicaid-enrolled children who may lack access to other resources, we recommend increasing most of them to 100% of the benchmark as well.

With respect to Speech Therapy, Speech Language Pathologists working in EI must bill Speech/Hearing Therapy (92507), which is an encounter code, meaning that, regardless of session length, they can only receive a set amount in reimbursement. By contrast, PTs and OTs bill a code that reimburses $34.97 per 15-minute unit. A typical EI session, regardless of therapy type, is 60 minutes long. Therefore, a PT or OT can make $139.88 per session while an SLP can only make $72.01 per session. Due to this discrepancy, Early Intervention Colorado has implemented a supplemental payment for SLPs to attract them to the program, at significant cost to the state. The Medicaid rate for this service should be examined, either by restructuring the unit or increasing the rate, to better attract SLPs to serve the Medicaid population.

Alliance request for MPRRAC recommendation:

- Increase Early Intervention TCM (T1017+TL) to 100% of the benchmark, currently 73.60% of benchmark.
- Make no change to "Pediatric Comprehensive Care Package" (T1026+TL), currently 101.60% of the benchmark, but only based on two other states (Missouri and North Carolina)
- Increase the following EI therapy codes to 100% of the benchmark:

    - Therapeutic Activities (97530, currently at 97.80%)
    - Sensory Integration (97533, currently at 91.10%)
    - Oral Function Therapy (92526, currently at 86.60%)
- Restructure or significantly increase:
    - Speech/Hearing Therapy (92507, currently at 93.40%) to better attract SLPs
- Make no change to:
    - Therapeutic Exercises (97110, currently at 108.80%)

Targeted Case Management

Targeted Case Management is a comprehensive service through which Case Management Agencies and Case Managers (or Service Coordinators) assist individuals and families to access long-term supports. TCM services include intake, eligibility determination, service plan development, arranging services through a variety of providers, service coordination, service monitoring, navigating Colorado's long-term care system, and more. Case Management is the lynchpin for anyone needing to access long-term services, including Home and Community-Based Services waivers for people with disabilities.

In 2023-24, Colorado underwent a massive systems change called Case Management Redesign, consolidating the delivery of case management services which had previously been bifurcated by population. This occurred at the same time as the implementation of a new state database to manage case management activities (the Care and Case Management System or CCM), as well as the unwind of the Public Health Emergency which required thousands to be redetermined eligible for Medicaid benefits. Colorado is still in a stabilization period for TCM, and the transition has been incredibly challenging for Case Management Agencies and people receiving long-term services to navigate. Additionally, Colorado is in the process of implementing additional system changes this summer, which have exacerbated retention and turnover issues among Case Managers.

We appreciate HCPF's willingness to work with us in identifying states for its benchmark analysis. Our members did a deep dive into other states and found only one – Montana – we felt was a good comparison given the unique ways Colorado has structured its TCM benefit and the roles and responsibilities of our Case Management Agencies. States structure their case management services in a variety of ways, and very few are alike. For example, in some states, government agencies conduct intake, enrollment, and even TCM activities rather than a network of private providers. States also have a variety of ways that they set up payment for TCM, and Colorado's choice to use a monthly service unit is quite unique. These nuances as well as others made finding comparable states very difficult and raises concerns about the validity of a benchmark analysis.

Despite these challenges, HCPF continued with its benchmark analysis, which finds that Colorado's TCM rate is low compared to the other selected states. Colorado CMAs are operating within a newly redesigned system with a new payment methodology and serving a large, diverse population of Medicaid members. While they are still getting their feet under them, so to speak, they are already beginning to see shortcomings with the TCM rate. And especially because CMAs are still stabilizing post-redesign, they are struggling with recruitment challenges and high turnover among Case Managers, which impacts service quality and the ability of Medicaid members to access services timely. Case Management is the gateway to the inherently cost-saving Medicaid waiver services that help people avoid costly institutional stays, and quality service coordination can help to reduce costs on its own. Finally, similar to EITCM, there is no Medicare or private rate to use in the benchmark analysis.

Alliance request for MPRRAC recommendation:

- Increase TCM rate to 100% of the benchmark, currently 87.25% of benchmark.

Physician Services – Neuro/Psychological Testing Services

Neuro/Psych testing is required for people with intellectual and developmental disabilities, including Autism Spectrum Disorder, to meet eligibility criteria for critical services and supports within Medicaid, including Home and Community-Based waiver services and behavioral therapies. These evaluations are time-consuming, expensive, and must be completed by a doctoral level clinician with extensive training, yet they are reimbursed $7/hr less than Board Certified Behavior Analysis for supervision and $20/hr less than master's-level mental health therapists. Due to this misalignment of the rate with respect to both the complexity of the services provided and the qualifications required of the provider to deliver them, many qualified psychologists opt out of providing evaluations for Medicaid, resulting in limited access to these essential diagnostic services.

HCPF's benchmark analysis uses Medicare rates as the comparison for the codes used for these evaluations (96130, 96131, 96132, 96133, 96136, and 96137). However, Medicare rates do not reflect realistic market costs for these services, resulting in a skewed benchmark analysis. Using data from Wyoming's recent rate review for these services (see slide 4), Colorado's 2025 rates are lower than surrounding states' 2023 rates, especially for 96133 and 96137, which account for the vast majority of billing:

		2025 current	2023							
		Colorado	Utah	Montana	Wyoming	Nebraska	South Dakota	AVERAGE	% Comparison	
96132	60 min	$134.51	$ 162.24	$ 161.84	$ 116.99	$ 120.76	$ 106.88	$ 133.74	100.6%	capped at 1 unit
96133	60 min	$102.58	$ 162.24	$ 125.52	$ 89.23	$ 66.60	$ 106.88	$ 110.09	93.2%	
96136	30 min	$68.10	$ 81.12	$ 54.93	$ 41.94	$ 66.60	$ 53.45	$ 59.61	114.2%	capped at 1 unit
96137	30 min	$49.84	$ 81.12	$ 49.48	$ 38.82	$ 31.08	$ 53.45	$ 50.79	98.1%	

Alliance members report that waiting lists for evaluations are growing because not many psychologists are willing to accept the Medicaid rate. Currently, wait list times for ASD evaluations are between 12 and 24 months, delaying the start of essential services. Out of desperation, some families elect to private-pay thousands of dollars for these evaluations rather than utilize their Medicaid benefits in order to get timely access to services, but this option is simply unaffordable for many.

Additionally, this gap has broader implications for the entire system because many commercial plans align their reimbursement structures to Medicaid fee schedules, keeping commercial rates artificially low.

Alliance members report that existing rates do not cover the cost to deliver the services, and a minimum 30% increase is needed to make them financially sustainable and support continued provider participation.

Finally, two billing codes—96110 (developmental screening) and 96127 (emotional/behavioral screening) have historically not been open to psychologists and other qualified providers under Medicaid. These codes are not included in the April 2025 Behavioral Health Billing Manual. Enabling access to these codes would provide a valuable mechanism for early screening and identification and should be considered as part of this year's review.

Alliance request for MPRRAC recommendation:

- Increase the following codes by a minimum of 30%:
  - 96130 (PSYCL TST EVAL PHYS/QHP - 1ST hour)
  - 96131 (PSYCL TST EVAL PHYS/QHP – each additional hour)
  - 96132 (NRPSYC TST EVAL PHYS/QHP - 1ST hour)
  - 96133 (NRPSYC TST EVAL PHYS/QHP - each additional hour)
  - 96136 (PSYCL/NRPSYC TST PHY/QHP - 1ST hour)
  - 96137 (PSYCL/NRPSYC TST PHY/QHP – each additional hour)
- Open 96110 (developmental screening) and 96127 (emotional/behavioral screening) to qualified behavioral health providers

Alliance appreciates the MPRRAC's thoughtful consideration of these community provider perspectives, and we are happy to provide additional information as requested by the committee or HCPF staff.

Elizabeth Freudenthal
Colorado Children's Hospital
Services: Pediatric Primary and Preventive Care, Neuro/Psychological Testing Services, Durable Medical Equipment

Thank you for the opportunity to provide feedback on this year's cycle of codes under MPRRAC review. Attached you'll find the letter outlining the Children's Hospital Colorado recommendations for maintaining or raising rates in three priority areas which we believe would be the state's best investment in short- and long-term savings and improved access to care: pediatric primary and preventive care; neuropsychology evaluations; and DME supplies needed for in-home infusion, port maintenance and central line needs.

Director of Medicaid Strategy and Initiatives Kevin J.D Wilson, Policy and Advocacy Specialist Erica Pike and I are available for any follow-up questions or comments from the HCPF team or from members of MPRRAC. Please don't hesitate to connect with us, as we'd love to be partners and collaborators in this process. Kevin, Erica and I could connect your teams with our clinical and business leaders in order to provide any additional information that may help.

Dear Dr. Adamson and members of the Medicaid Provider Rate Review Advisory Committee,

Thank you for accepting public input in the annual reimbursement rate review process for Medicaid providers in Colorado. We appreciate your service to Colorado Medicaid members and those who care for them. We also appreciate that your work on this committee has become even harder, as our state prepares to accommodate unprecedented cuts in federal funding for Medicaid and other public-serving healthcare programs.

Children's Hospital Colorado is one of the leading not-for-profit pediatric healthcare providers in the country, as well as the largest provider of Medicaid services for children in the state of Colorado. Like you, we care deeply about the health and well-being of children in our state, and we aim to preserve and expand their access to care within ever-tightening budget constraints. We hope to collaborate in pursuit of these shared goals.

In that spirit, we strongly urge the MPRRAC to prioritize increasing rates for three sets of codes that we have identified as highest priority for return on investment, short- and long-term cost savings, and improved health over the lifespan.

MPRRAC support to raise these rates would strengthen and potentially expand these provider networks, improving access to quality care and lowering costs over time:

- Pediatric primary care
    - Reduce short- and long-term costs across state agencies by keeping kids healthy and helping them become healthy adults
- Neuropsychological assessments
    - Support better community-based care by giving families and medical home providers the best understanding of each child's needs early enough to intervene most effectively
- DME supplies for in-home infusions
    - Keep kids out of the hospital with enough supplies to manage infusions, central lines, and ports at home

Costs associated with these services for children and youth are not adequately represented by the Department of Health Care Policy and Financing's (HCPF) "Medicare plus peer state" methodology. While this methodology may be applicable to adult populations, pediatric care requires substantively different models for care teams, administration, support staff, facilities and supplies.

As a result, many of the benchmark values for these services are not as relevant as methodologies based on full costs for providing this care in Colorado.

The remainder of this letter provides detailed information about each benefit area and priority codes.

Physician Services: Pediatric Primary Care

Well Visits, Evaluation and Management (E&M) Codes

HCPF partnered with pediatricians across the state over several years to develop an Alternative Payment Model (APM) specific to the care needs of children and youth. HCPF staff were very responsive throughout this process, leading to the proposal to create a separate APM for pediatrics known as PACK—Payment Alternatives for Colorado Kids. However, too many limitations prevented HCPF from implementing PACK in a way that would meet the needs expressed by pediatricians. These needs remain and are compounded by the sharp rise in uninsured kids since May 2023, capitation-based payment models, and a major contraction in the primary care safety net. Fee-for-service rates remain central to practice sustainability, especially since current payment reform models are not aligned with pediatric care. MPRRAC has an opportunity to bolster the pediatric medical home network by raising these rates.

Well-child visits allow pediatricians to complete a comprehensive assessment of a child, provide preventive care, and identify areas in a child's development that may

need evaluation. These visits have health and economic benefits and promote health equity.

However, according to CMS data through mandatory state-based Early and Periodic Screening, Diagnostic and Treatment (EPSDT) reporting, Colorado currently has one of the lowest rates of well-child visits in the country.

Currently, Colorado pediatricians are paid an average 96.07% of benchmarks for these priority pediatric primary care codes:

- Evaluation and Management (E&M)
    - 99202-5, 99381-5, 99391-5, 99417-8, 99202, 99211-5
- Screenings
    - G8431, G8510
    - 99173, 99177, 92567
    - 96110
- Routine well care
    - 96415-6
    - 83655
    - 87880
    - 81025
    - 81002

We recommend the MPRRAC advise HCPF to increase these to at least 110% of the benchmark in order to preserve access to pediatric primary care in the adverse fiscal environment described above.

Vaccine administration

Pediatric providers are contending with a growing wave of anti-vaccine misinformation. Providers now need to spend much more time counseling families on vaccine safety and answering questions to ensure families have accurate information to make an informed consent, and that time is not adequately compensated. We recommend the MPRRAC and HCPF raise vaccine administration rates to the federally allowed regional maximum: 90460, 90471-4. Furthermore, we respectfully urge the MPRRAC to maintain or raise injection code 96372 and RSV administration codes 96380-1.

Family Planning

An important part of adolescent well-care and prevention, birth control services are not appropriate to benchmark to Medicare. We recommend that implant insertion codes, 11981-3, stay at the same rates. Intrauterine device codes, 58300-1, should be

reimbursed at the same rates or higher than implant insertion because these clinical procedures are more complicated.

Physician Services: Neuropsychological Assessments

We recommend prioritizing raising rates for six codes that are used to help diagnose and treat the needs of young people with the most complicated conditions. The clinicians that assess patients at Children's Hospital Colorado have expertise in diagnosing children and youth who have combinations of conditions including brain injuries, congenital disorders, developmental and/or cognitive impairments, mental health conditions, and other health care needs. To diagnose children with this level of complexity, our teams use these three sets: 96116/21, 96132/3, and 96136/7.

The first two, 96116/21, are not included as the most commonly utilized codes, but our teams rely on them for reimbursement for multidisciplinary team care required to best understand and treat the needs of these patients.

96132/3, neuropsychological evaluation for first and subsequent hours, are required for diagnosing people with these complex conditions. They require a doctoral-level professional to integrate standardized test results, medical history, diagnostic interviewing, and neurobehavioral examination in order to provide a comprehensive diagnostic formulation. Because these evaluations typically take four to six hours, the additional time code 96133 is equally important and should be reimbursed the same rate as 96132.

96136/7 are used in conjunction with 96132/33 to account for time spent in face-to-face administration and scoring of the standardized neuropsychological tests required for the evaluation.

All these codes, so essential to the sustainability of our programs, are reimbursed significantly below the cost of hiring and retaining the professionals required to meet our community's needs. For contrast, our clinicians have colleagues in other states in the same roles whose Medicaid reimbursements pay for their entire salaries.

Because these reimbursements are so low, we struggle to find funding to retain clinical faculty. Practices, providers, and healthcare systems simply cannot hire more clinicians to meet community needs and shorten the one-to-two year waiting lists. We know that early diagnosis and treatment results in the best outcomes. The longer that children wait for a comprehensive diagnosis, the longer it takes to treat them effectively, and crucial developmental windows for intervention may be missed. Furthermore, their care will be more costly because they will require more and more expensive services over the course of their lives. In the long term, they may ultimately struggle to live and work independently as adults.

We believe that within budget neutrality, MPRRAC could find ways to increase these rates in order to prioritize safe, effective diagnosis and treatment of kids with highly complex needs.

Finally, 96127 is a screening code that is used differently in Colorado compared to other benchmark states. Because Colorado has designated that code to meet federal requirements to flag Autism Spectrum Disorder Screenings in claims, its benchmark should not be the same code in other states, which use it for much shorter, simpler services according to its definition.

Durable Medical Equipment

In order to safely discharge patients with complex needs from an inpatient stay at Children's Hospital Colorado, our providers and care coordinators work with Durable Medical Equipment (DME) providers, home health agencies, and pharmacies to ensure a safe transition back into home and community-based care. When children receive DME supplies at home and are able to live in their community, they avoid high cost, lengthy hospital stays. They are healthier and happier, and their families have more stability. For children and youth with ongoing home-infusion, central line management and port maintenance needs, we've been able to secure appropriate DME supplies without significant barriers to care. Such DME supplies include items related to central lines including needles, pumps, and pump stands.

A few of these codes are above the baseline, using HCPF's Medicare-based methodology. However, many are in the 70-80% range. And for parenteral nutrition, a form of intravenous nutrition that bypasses the gastrointestinal tract, most supply rates are significantly below the benchmark, some as low as 16%.

Medicare-based methodology for these DME supplies present two challenges for access-based analysis:

1. DME supplies for children and youth require much more variety, adaptability and flexibility than for adults. Kids' bodies change constantly, so DME and nutrition formulas need to change with them. Companies cannot benefit from economies of scale if they focus on supporting young people.
2. For children and youth with ongoing in-home DME needs, companies are not dropping off supplies once and exiting care. Instead, companies are often now part of care teams, supporting the frequent changes required by ongoing care for young people with complex care needs

In short, pediatric DME is more expensive.

For the handful of home-infusion supply rates above the baseline, those rates reflect years of collaboration between HCPF, suppliers and advocates to raise rates to a level that facilitates sustainable care.

However, for the rest, and especially for parenteral or total parenteral nutrition (TPN), the low DME rates are a significant factor in access barriers. Network adequacy for these specialized services has been a significant concern, and one that the Colorado General Assembly took up in the 2025 legislative session. Currently, there is a single pharmacy in Colorado providing access to parenteral nutrition for pediatric patients with Medicaid. On May 28, 2025, Governor Polis approved a bill to improve dispensing fees related to parenteral nutrition.4 We recommend that DME supply reimbursements also be raised to ensure adequate access to all the supplies needed for Colorado Medicaid patients who need this care.

According to the American Society for Parenteral and Enteral Nutrition, many infusion pharmacies have stopped supplying parenteral nutrition across the nation, particularly for children because of financial pressures.5 Last October, one large national company, an infusion pharmacy that provided an estimated 15% of infusion services across the country, drastically cut these services due to high overhead costs associated with providing infusion services, labor costs, reimbursement delays and supply shortages, according to KFF News.6 DME supplies for children and youth with complex care needs are keeping them safely at home and preventing short- and long-term costs associated with more frequent hospital visits, exacerbation of conditions, or unnecessary inpatient stays. Please maintain rates that are currently above the benchmark and raise the rest of these rates to at least 90% of benchmark: A4220-2, A4230-1, E0779-80, 82-83, E0791, J1642, and K0455.

In conclusion, our team has developed these recommendations after months of consultation with clinicians and business managers across our organization, as well as with several community partners. We believe that these three sets of prevention services would be among the most effective investments for the Colorado Medicaid program to improve health and lower costs over the short and long-term. We also believe these to be areas where valuable state resources would have the most impact in improving access to care.

Thank you again for your openness to public input. We look forward to collaborating with you through this rate review process. Please feel welcome to reach out to our team with any questions you might have.

Resources:

https://www.cdc.gov/mmwr/pdf/other/su6302.pdf

https://pmc.ncbi.nlm.nih.gov/articles/PMC3037784/

https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment

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Services: Physicians Services - ENT, Physicians Services - Family Planning, Physicians Services - Neuro/Psychological Testing Services, Physicians Services - Primary Care E&M, Physicians Services - Vaccines Immunizations, Laboratory and Pathology Services, Vision Services

Dear Medicaid Provider Rate Review Advisory Committee:

On behalf of the American Academy of Pediatrics and our over 800 members, we strongly urge you to protect and enhance the pediatric codes currently under your review.

Unlike adult care, pediatric care has no Medicare equivalent. As such, many of the current pediatric codes listed were developed through rigorous, state-led processes to ensure children in Colorado receive equitable, preventive, and developmentally appropriate care. These carefully considered codes are not arbitrary—they are the result of:

- Robust HCPF-led stakeholder efforts, including APM 2 and the Payment Alternative for Colorado Kids (PACK) designed to improve child health outcomes and address payment inadequacy for pediatric care;
- State law, including HB19-1233, which mandates increased investment in primary care; and
- Legal precedent, which affirmed that Colorado must fully cover and pay for services under EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), the federal standard that ensures children on Medicaid get the care they need when they need it.

These pediatric-specific codes are found across various subcategories under the physician services category. The specific codes include well child checks, immunizations, developmental and depression screenings, labs, and other essential care. In other words, the everyday tools pediatricians use to keep kids healthy, catch problems early, and make sure families get the help they need. A reduction in these

codes would undo years of careful policymaking and directly threaten access to care for Colorado's children.

Broadly speaking budget cuts disproportionately harm vulnerable communities, particularly children, who are the least equipped to bear the burden. Children are not little adults and having them lumped into broad budget decisions without consideration for their own unique needs can have unintended and harmful consequences for them and their care. Children have unique healthcare needs that require focused promotion, prevention, and early intervention strategies for long-term health. When payment for pediatric services is reduced or delayed, it puts kids' health at risk.

We know you have a difficult task in front of you and we acknowledge there are no simple solutions. However, one thing is clear: Colorado must prioritize the health and well-being of our children when vital budget decisions are being made. As pediatricians, we are guided by the principle to "do no harm." We ask the same of you when it comes to the youngest members of our state.

On behalf of AAP Colorado and the thousands of children and families served by our members, we thank you for your consideration to protect and enhance the Medicaid codes listed below that ensure all Colorado children, no matter where they live or what their family earns, have access to the care they need to grow and thrive.

Critical Pediatric Codes to Under Review as Outlined in 7/18 Meeting Agenda

MPRAAC Service Category: Physician Services

ENT

AAP-CO Recommendation: Protect kids by protecting benchmark ratio

Sensory & Other Screenings

- 92567 – Tympanometry

Family Planning

AAP-CO Recommendation: Protect kids by protecting benchmark ratio for all codes

Family Planning

- 11981 – Contraceptive implant insertion
- 11982 – Removal

- 11983 – Removal and reinsertion

Neuro/Psychological Testing Services

AAP-CO Recommendation: Protect kids by protecting benchmark ratio for all codes. Federal law mandates coverage of EPSDT

services for children. Further, these 5 codes are critical in supporting a child's access to preventive developmental and behavioral health services.

Developmental & Behavioral Health Screens

- 96110 – Developmental screen with scoring (EPSDT)
- 96110-EP – Developmental screen with scoring (EPSDT)
- 96127 – Behavioral/emotional screen (autism spectrum disorder screening; EPSDT)
- G8431 – Positive depression screen, follow-up documented
- G8510 – Negative depression screen, no follow-up required

Primary Care E&M

AAP-CO Recommendation: Protect kids by ENHANCING benchmark ratio for all codes to at least 100%. Under HB19-1233, Colorado is required to increase primary care investment, yet CIVHC data shows Medicaid primary care spending fell from 19.5% in 2022 to 19% in 2023. Aligning pediatric benchmarks with adult ratios supports this mandate.

Well Child Checks

- 99381–99385 – New patients (infant to age 18+)
- 99391–99395 – Established patients (infant to age 18+)

Office visits - acute and chronic or complex disease management

- 99202-99205 – New patients
- 99211-99215 – Established patients

Vaccines Immunizations

AAP-CO Recommendation: Protect kids by ENHANCING all benchmark ratios to a minimum of 100% and protect those already exceeding 100%. This is critical to safeguarding children's health and ensuring timely access to essential vaccines.

Immunizations

- 90471–90474 – Immunization administration (IM/oral/nasal)
- 96372 – Injection (therapeutic/prophylactic)
- 96380–96381 – RSV monoclonal antibody administration

MPRAAC Service Category: Laboratory and Pathology Services

AAP-CO Recommendation: Protect kids by ENHANCING all benchmark ratios to a minimum of 100% and protect those already exceeding 100%. This is critical to early identification of childhood disease and prevention.

Labs & Procedures

- 83655 – Lead screening (EPSDT)
- 87880 – Rapid strep test
- 81025 – Urine pregnancy test
- 81002 – Urinalysis (non-automated, no scope)
- 36415–36416 – Blood draw (venipuncture/capillary)

MPRAAC Service Category: Vision Services

AAP-CO Recommendation: Protect kids by ENHANCING all benchmark ratios to a minimum of 100% and protect those already exceeding 100%. This is essential to protecting children's eye health and supporting their development.

Vision Services

- 99173 – Visual acuity
- 99177 – Instrument-based ocular screening

Verbal Feedback from Quarterly MPRRAC Meetings

The following are public comments given during the first three quarterly meetings of the Medicaid Provider Rate Review Advisory Committee (MPRRAC) public meetings. Each meeting is broken down by subcategories. Please note that some categories were reorganized, renamed, or added after the March meeting. Subcategories not listed did not have public comments. All feedback has been summarized to the best of HCPF's ability.

March 21, 2025

Dialysis and Dialysis-Related Services

- Two stakeholders requested rate increases for codes 821, 831, 841, and 851. One cited gaps between current rates and Medicare benchmarks (e.g., 14% increase needed in Colorado Springs, 8.7% in Denver). Stakeholders shared on the financial strain of serving 1700 patients across 27 clinics, and emphasized that missed dialysis treatments are linked to a 40% increase in hospitalization risk. A stakeholder shared that Medicaid reimbursement ($228/treatment) falls well below actual costs ($348), resulting in ~$17,000 annual loss per patient. One stakeholder serves 90 patients in rural Colorado, where over 50% of patients rely on Medicaid. They requested rate increases to maintain clinic viability in rural areas.

Prosthetics, Orthotics and Disposable Supplies (POS)

- An advocate from a prosthetics provider group, representing 20 clinics in Colorado and affiliated with the Orthotics and Prosthetics Association, requested a reimbursement increase from 72% to 80% of Medicare rates, citing unsustainable reimbursement due to inflation and COVID-related impacts. Two commenters referenced a state benchmark analysis they had submitted and emphasized the importance of aligning with Medicare for specific codes, including L2006, L5973, and L6880, particularly for advanced prosthetic technologies. It was noted that approximately 99 codes are reimbursed under a cost-plus methodology that includes clinical and administrative time. A manufacturer representative supported increasing reimbursement rates to 80% of Medicare. Some stakeholders offered analysis of orthotics and prosthetics codes for the committee's consideration.

Speech Therapy

- Multiple SLPs, including clinic owners and providers from rural and urban areas, emphasized the challenges of delivering care under current Medicaid reimbursement rates. They noted geographic limitations, no-

show financial losses, travel burdens, and reimbursement structures that limit billing to one code per day. Several commenters pointed out that ST receives lower reimbursement than PT/OT despite providing similar levels of service and facing high demand. Stakeholders shared concerns about losing providers due to unsustainable rates and highlighted the negative impacts on access to care, especially in rural regions. Some raised questions about the higher reimbursement rate for the telehealth version of code 92507 compared to in-person, and called for clarification and realignment.

Neuro/Psychological Testing Services

- A representative from a pediatric hospital policy team noted that Colorado Medicaid requires the use of codes 96110 and 96127 in highly specific ways that differ from national practices. For example, 96127 is used specifically for autism screening in Colorado, whereas other states may use it more broadly and this may distort rate comparisons. The speaker also highlighted that these evaluations are complex and time-intensive, often requiring multiple sessions and extensive interviews. She requested a reconsideration of the analysis methodology.

Ophthalmology Services

- An ophthalmologist and surgeon expressed concern that current reimbursement rates are so low they no longer cover the cost of service. They stated that due to rising costs of staff, rent, equipment, and inflation, Medicaid rates make it financially unsustainable to continue seeing Medicaid patients, despite a desire to do so. They emphasized that Medicaid beneficiaries are at risk of losing access to vital surgical services.

Primary Care Evaluation and Management Services

- A representative from a pediatric health system emphasized the financial strain on safety net primary care providers during the Medicaid unwinding period. The loss of Medicaid enrollments and increase in uncompensated care were straining budgets. They advocated for increasing reimbursement for preventive E&M codes and vaccine administration, particularly given the challenges of implementing pediatric-specific payment reform within current models.

Targeted Case Management (TCM)

- A stakeholder from a regional case management agency and advocacy organization expressed appreciation for the complexity of this work but cautioned that using other states as benchmarks may be misleading due to differences in billing models, provider roles, and state policies. They requested greater transparency into HCPF's rate-setting process for

TCM. Another commenter from a disability policy organization voiced concern that current funding levels may be insufficient to support new requirements.

July 18, 2025 and July 25,2025

DIDD Dental Services

- The Colorado Dental Association recommended looking at the utilization percentage of a rate in conjunction with the DIDD rate amount, to see which rates that are most highly utilized are also in need of an increase, to prioritize those rates, particularly when budget may be challenging to get any increases to rates.

Durable Medical Equipment

- Children's Hospital Colorado submitted a letter with the following DME code recommendations: DME supplies for children and youth with complex care needs are keeping them safely at home and preventing short- and long-term costs associated with more frequent hospital visits, exacerbation of conditions, or unnecessary inpatient stays. They asked that the committee please maintain rates that are currently above the benchmark and raise the rest of these rates to at least 90% of benchmark: A4220-2, A4230-1, E0779-80, 82-83, E0791, J1642, and K0455.

Orthotics

- There were nine public comments for Orthotics including several from Cranial Kids. Stakeholders talked about the importance of this service, the intricacy of the treatment, and encouraged MPRRAC not to lower rates.

Enteral Formula

- There were several public comments from stakeholders from Sentido Health and Aveanna Healthcare encouraging MPRRAC not to lower rates for enteral formula.

Laboratory and Pathology Services

- A clinical practicing medical geneticist and a representative from GeneDx commented on the complexity of lab testing.

Outpatient PT/OT/ST

- A stakeholder from Alliance representing early intervention brokers and providers spoke on the importance of the services.

Speech Therapy

- Stakeholders from Alliance and Aspen Speech Therapy encouraged the committee not to lower rates.

Family Planning

- A pediatric resident at Children's Hospital Colorado and member of the Colorado Chapter of the American Academy of Pediatrics, emphasized the importance of access to adolescent contraceptive care through Medicaid and Title X-funded clinics. They advocated for maintaining high reimbursement rates for long-acting reversible contraceptives (LARCs), particularly implant insertion code 11981–11983, to preserve access. They also recommended increasing reimbursement for IUD insertion code 58300 due to its complexity and importance and cited a 50% drop in teen pregnancy following improved LARC access in Colorado.

Neuro/Psychological Testing Services

- A Clinical Psychologist highlighted a 1–2 year waitlist for children needing neuropsych testing, especially those who are neurodivergent. They pointed out confusion in mixing physician and clinical psychologist services in code groupings and stated an inability to access key codes: 96217, 96110, 96113. They cited inadequate Medicaid provider availability—fewer than 100 individuals statewide. They stressed that early intervention (ages 2–6) yields the best outcomes and that the waitlist is a major barrier. A Pediatrician at Peak Pediatrics, warned that payment reductions put pediatric patients at risk, given their unique needs and advocated for enhancing the benchmark ratios for 96110, 96127, G8431, and G8510. This provider supported that neuropsych provider shortages are real, and the waitlist concerns are not exaggerated. A Neuropsychologist at Children's Hospital Colorado, called for raising rates on codes 96116, 96121, 96132, 96136, 96137. Providers questioned the relevance of Medicare benchmarks for pediatric care, noting that pediatric testing takes longer than for adults. A Clinical Psychologist and Clinic Owner described a wage inversion where Master's-level therapists earn more than PhDs due to low assessment reimbursement.

Primary Care Evaluation and Management

- A Pediatrician at Peak Pediatrics serves a population that is 70% Medicaid. They described pediatric practices as being in crisis due to chronic underpayment, noting two closures in 2024 and difficulty retaining MAs and RNs, who are leaving for better-paying adult care roles.Cited a shortage of primary care physicians and difficulties attracting new providers. They urged that the "bread and butter" codes be brought to 100% of benchmark to ensure the survival of quality pediatric care in Colorado: 99381–99385, 99391–99395, 99202–99205 and 99211–99215.

Radiology

- A neuroradiologist at Denver Health and VP of the Colorado Radiologic Society emphasized the critical role of radiology in supporting all other specialties Noted the impact of any reductions at hospitals like Denver Health and Children's Hospital Colorado, where Medicaid patients make up a large share. He advocated for maintaining at least 80% of Medicare reimbursement. A Pediatric Neuroradiologist with the Colorado Radiologic Society stressed that pediatric radiologists serve the most vulnerable populations often during crises and called for appropriate reimbursement, especially for children.

Vaccines and Immunications

- A Pediatrician at Children's Hospital Colorado urged the committee to prioritize increases in pediatric-specific administration and requested increases for: 90460, 90471–90474, 96372, and RSV codes 96380–96381. HCPF's vaccine SME added that the state does not reimburse for the vaccine itself for members under 19 who qualify under the Vaccines for Children (VFC) Program and that the vaccine administration is capped at the VFC regional maximum of $21.68. She expressed support for increasing rates to the allowable maximum and emphasized the importance of avoiding any reductions.

August 22, 2025

Dialysis Facility

- The stakeholder from Fresenius Medical Care emphasized that three key codes: 821 (hemodialysis and home hemodialysis training), 841 (continuous ambulatory peritoneal dialysis and training), and 851 (continuous cycling peritoneal dialysis and training) are the most frequently billed in dialysis settings and remain under-reimbursed.

DIDD Dental Services

- The Director of Government Relations for the Colorado Dental Association, highlighted several frequently used and under-reimbursed codes: D1110, D1206, D4910, D4342, and D4341. They requested continued consideration to increase their reimbursement. She also flagged missing anesthesia codes (D9219, D9222, D9223) from the DIDD fee schedule, noting these procedures often require additional time due to underlying medical complexities.

Enteral Formula

- A representative from Aveanna Healthcare, thanked the MPRRAC for its recommendation to maintain current reimbursement rates for enteral formula.

Other and Disposable Supplies

- A representative from Aveanna Healthcare, expressed appreciation for MPRRAC's recommendation, noting its importance for many of the codes in this category, particularly those related to the provision of enteral nutrition therapy services. He highlighted challenges providers face, such as tariffs on supplies.

Outpatient PT/OT/ST

- A stakeholder from the American Physical Therapy Association thanked the Committee for increasing select physical therapy (PT) codes and submitting an inflation adjustment. He reiterated that the exclusion of exercise as preventive care is an oversight, emphasizing that evidence strongly supports exercise as a form of preventive healthcare. He urged MPRRAC to reconsider this classification, noting that while short-term costs may rise, long-term health outcomes and cost savings would justify the investment.

Neuro/Psychological Testing Services

- A representative from Children's Hospital Colorado expressed strong support for the July MPRRAC recommendations. She emphasized that telehealth is critical for pediatric neuro/psychological testing, as it can provide clinically superior assessments due to increased comfort for children with autism in familiar home environments. She said that codes without benchmarks remain significantly under-reimbursed despite the proposed 10% increase and that reflects approximately a 70% deficit. She stressed that Medicare benchmarks are not appropriate for pediatric testing due to differences in service complexity and duration.

Neurology

- A stakeholder from Alliance Neurodiagnostics, expressed support for the recommendation to align reimbursement for ambulatory EEG monitoring with the Medicare benchmark. He emphasized the importance of this service for vulnerable populations. He noted that current Medicaid rates are significantly below both the cost of delivering care and Medicare reimbursement levels. The primary codes he referenced were 95700 and 95715.